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NATIONAL HEALTH INSURANCE

PUBLIC HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
NINETY-FOURTH CONGRESS
FIRST SESSION

NOVEMBER 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20;
DECEMBER 2, 3, 4, AND 5, 1975

PART 1 OF 3
(NOVEMBER 5, 6, 7, 10, AND 11, 1975)

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NATIONAL HEALTH INSURANCE

WEDNESDAY, NOVEMBER 5, 1975

U.S. House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met at 9:03 a.m., pursuant to notice, in the committee hearing room, Longworth Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. The committee will come to order.

I welcome all of you to these public hearings. I would like to begin by saying that these hearings represent one more step in the subcommittee's active consideration of national health insurance. During the past 10 months, the subcommittee has been compiling a comprehensive public record on the problems and issues involved in the health care delivery organizations and financing of the United States, matters which go to the very heart of public debate on national health insurance.

In addition to a large number of statements submitted to the subcommittee by interested persons at the beginning of this year, the several panel discussions held by the subcommittee with members of its advisory panel on national health insurance have contributed greatly to the clarification of the issues we all must address.

In these hearings our objective is to build on this record by providing an opportunity for the full expression of our population on this fundamental question of public policy.

I hardly need emphasize the importance of these hearings. They have been scheduled to take place at a time when the full membership of the Committee on Ways and Means will be free to attend and participate.

Chairman Ullman has made a special point of urging members of the full committee to be here as much as possible. It is clear that the public and congressional attention will be focused on these proceedings and that expectations are high that progress toward a solution of the health care problems facing our Nation will flow from them.

Certainly it is my hope that the testimony presented here in the next several weeks will play a crucial role in helping to shape the congressional response to the public demand for an effective, workable, and broadly acceptable national health insurance program.

In light of these expectations I am disappointed by the administration's reluctance to testify or to contribute at this time to the dicussion of the substantive issues involved. Eighteen months ago Secretary Weinberger told this committee that comprehensive health insurance is a long debated idea whose time for enactment has arrived.

That statement is even more true today than then.

If the economic situation is improving as rapidly as the President has recently told us, I feel confident that the administration will not long remain dormant on this problem.

As administration spokesmen and many of us in Congress were saying 18 months ago, the problems which face us are severe and getting worse in many respects.

Certainly, the continued unchecked inflation in health care costs is both fueling inflation and retarding economic recovery. I believe an effective national health insurance program can help deal with these problems, and I urge the administration to begin working with us to develop such a program.

But whatever the position of the administration. I believe it is critical that the debate now move forward and that the public expression of all views be heard without further delay.

At this point, without objection, the subcommittee's press release announcing these hearings will be inserted in the record.

[The press release follows:]

[Subcommittee on Health press release, Aug. 19, 1975]

SUBCOMMITTEE CHAIRMAN DAN ROSTENKOWSKI (D., ILL.), SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, ANNOUNCES HEARINGS ON NATIONAL HEALTH INSURANCE, BEGINNING TUESDAY, OCTOBER 28, 1975[1]

Subcommittee Chairman Dan Rostenkowski (D., Ill.) of the Subcommittee on Health of the Committee on Ways and Means announced today that the Subcommittee will hold public hearings on the subject of national health insurance beginning on Tuesday, October 28, 1975, at 9:00 a.m. in the Committee's main hearing room, Longworth House Office Building.

It will be recalled that the Committee on Ways and Means held extensive hearings on the broad subject of national health insurance during April through July of 1974. Also the Subcommittee on Health solicited written comments from interested organizations and the public generally earlier this year in order to supplement and bring up to date testimony taken during 1974. (This written record has now been published.) It should be noted also that the Subcommittee on Health began a series of panel discussions on the broad subject of national health insurance last month.

In view of the heavy schedule of the Committee and the limited time available for this hearing, it will be necessary to allocate the amount of time available to each witness for the presentation of his direct oral testimony, and it will be mandatory for all witnesses not to exceed the time allocated for this purpose. Witnesses may be scheduled in panels formulated by the staff grouped according to subject matter. If the time allocation does not allow the witness to present his complete detailed statement the witness will have to summarize it with the understanding that the full statement will be included in the printed record of the hearing.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Cutoff Date for Requests To Be Heard.—Requests to be heard must be submitted by no later than the *close of business Friday, October 3, 1975.*

All requests should be submitted to John M. Martin. Jr., Chief Counsel, Committee on Ways and Means, Room 1102, Longworth House Office Building, Washington, D.C. 20515 (telephone: (202) 225-3625). Notification will be made as promptly as possible after the cutoff date as to when witnesses have been scheduled to appear. At that time guidelines for preparing for the appearance will accompany such notification. Once the witness has been advised of his date of appearance it is not posible for this date to be changed. If a witness finds that he cannot appear on that day, he may wish to either substitute another spokesman in his place or file a written statement for the record of the hearing in lieu of a personal appearance.

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[1] Later rescheduled to commence November 5, 1975.

Coordination of Testimony.—In view of the heavy schedule of the Subcommittee and the full Committee ahead and the limiited time available to the Subcommittee to conduct this hearing, it is requested and it is most important that all persons and organizations with the same general interest designate one spokesman to represent them so as to conserve the time of the Subcommittee and other witnesses, prevent repetition, and assure that all aspects of the subjects being discussed at this hearing can be given appropriate attention.

Written Statement in Lieu of Personal Appearance.—The Subcommittee will be pleased to receive from any interested organization or person a written statement for consideration for inclusion in the printed record of the hearing in lieu of a personal appearance. These statements will be given the same full consideration schedule, this will limit the total time available to the Subcommittee in which to conduct these proceedings. Thus, to assure fairness to all witnesses and all points of view, it will be necessary to allocate time to witnesses for the presentation of their direct oral testimony. Most witnesses will be limited to five (5) minutes for their verbal presentation. Exceptions to the rule will be severely limited and in any case only where broad national organizations are involved. Also, as indicated above, it may be necessary to ask certain witnesses to form panels in order to further consolidate testimony. If the witness wishes to present a long and detailed statement, it will be necessary for him to confine his oral presentation to a summary of his views while submitting a detailed written statement for the Subcommittee's consideration and for inclusion in the record of the hearing.

Contents of Requests To Be Heard.—The request to be heard *must* contain the following information, otherwise delay may result in the proper processing of a request:

(1) The name, address and capacity in which the witness will appear;

(2) a list of persons or organizations the witness represents and in the case of associations and organizations their total membership and where possible a membership list;

(3) An indication of whether or not the witness is supporting or opposing any specific proposal or proposals on which he desires to testify;

(4) If a witness wishes to make a statement on his own behalf, he must still nevertheless indicate whether he has any specific clients who have an interest in the subject, or in the alternative, he must indicate that he does not represent any client having an interest in the subject he will be discussing; and

(5) A topical outline or summary of the comments and recommendations which the witness proposes to make, which will form the basis for prepared summaries of the hearing.

Submission of Prepared Written Statements.—With respect to oral testimony, the rules of the Committee require that prepared statements be submitted to the Committee office at least 24 hours in advance of the scheduled appearance of the witness. Fifty (50) copies of the written statements would be required in this instance; an additional fifty (50) copies may be submitted for distribution to the press and the interested public on the witness' date of appearance.

As indicated above, any interested person or organization may submit a written statement in lieu of a personal appearance for consideration for inclusion in the printed record of the hearing. Such statements should be submitted by Thursday, November 6, 1975, in triplicate. An additional fifty (50) copies of written statements for the printed record will be accepted for distribution to the Subcommittee members, the press and the interested public if submitted before the final day of the public hearing.

Format of All Written Statements.—It will be necessary that all prepared statements contain a *summary of testimony* and recommendations and that throughout the statement itself pertinent subject headings be used.

Resubmission of Requests To Be Heard Where Requests Already Made.—If a prospective witness has already submitted a request to be heard on the subject of national health, the request should be resubmitted at this time furnishing the above information and otherwise conforming to the rules set forth for conducting this hearing.

Mr. ROSTENKOWSKI. Also, I wish to announce that the record will be kept open until December 5 for statements to be included in the record of these hearings.

I would also like to announce that it is the intention of the Chair to work through lunch and try to conclude these hearings in the middle of the afternoon.

I would like at this time to welcome our first witness, Dr. R. Lowell Campbell, Association of American Physicians and Surgeons, and Mr. Frank K. Woolley.

If you will, introduce yourselves and proceed with your testimony, gentlemen.

STATEMENT OF R. LOWELL CAMPBELL, M.D., PRESIDENT, AND FRANK K. WOOLLEY, EXECUTIVE DIRECTOR, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Dr. Campbell. Mr. Chairman, I am Dr. R. Lowell Campbell, a private doctor of Corsicana, Tex., appearing as president of the Association of American Physicians and Surgeons. Accompanying me is Mr. Frank K. Woolley, who is our executive director.

Do you wish me to continue my statement?

Mr. Rostenkowski. Yes, if you would, please.

Dr. Campbell. The proponents of compulsory politicalized medicine claim their schemes, which are deceitfully and wrongfully labeled National Health Insurance, will make more and better medical care available to everyone at less cost. Of course, that claim is not supported by evidence.

It is our purpose here to bring the assumptions on which proposals for politicalized medicine are based into focus with the fundamental beliefs of most of the people in this country, who are opposed to those schemes and all other attempts to use Government to oppress individual liberty.

Also, this testimony can be used by candidates for Congress, and others, to help develop plans and platforms for the coming elections.

We will look at the assumptions of the proponents of these so-called national health insurance schemes from various fundamental points of view: the assumption of the bureaucrats; politicians; labor union leaders; big business leaders; insurance companies; hospitals; hospital supply and equipment companies; and finally, medical organizations.

It should be clear that I am not talking about any groups that are opposed to compulsory politicalized medicine but only those that are for it.

First, let's consider the assumptions by the bureaucrats who favor compulsory politicalized medicine. A key assumption of bureaucrats is that they are infallible or, at least so far superior to ordinary patients, doctors, and hospital employees that all citizens should have a part of their earnings forceably taken from them and spent for them by bureaucrats because that way they will get "more appropriate and necessary medical care at reasonable cost."

Another assumption of bureaucrats is that the States of the Union have no independent authority under the U.S. Constitution which cannot be preempted by Federal employees by the devices of taxation, subsidy, and control.

A third assumption of the bureaucrats is that the Congress is an inferior branch of Government to be manipulated by the executive branch; the Constitution and courts are annoyances that must be "mitigated or removed"; and that the bureaucracy exists to control citizens, not to serve them—in fact, to mold citizens' behavior as bureaucrats deem appropriate.

A fourth assumption of bureaucrats is that the bureaucracy has the right and duty to usurp the legislative function through the promulgation of regulations which exceed legislative intent and which are couched in such ambiguous and tricky language, that the courts are repelled from trying to unravel the Machiavellian consequences.

A fifth assumption is that bureaucrats are more capable of deciding what is medically necessary and appropriate for individual Americans than doctors.

Sixth, bureaucrats assume that ordinary law-abiding citizens who are competent to vote and make choices among competing candidates for political office are to be considered incompetent to make proper choices for their own medical care in a free market and, therefore, should be denied the right to choose where, when, how, and by whom they should be treated.

Seventh, the bureaucrats assume that there is a definable need for medical care that Government can identify and provide at reasonable cost and satisfaction to patients if only obstinate physicians would subordinate themselves to dictation and control mechanisms devised and operated by a centralized bureaucracy.

Now, let's consider an assumption by politicians who favor compulsory politicalized medicine: The American people are really not bright enough to figure out the truth about compulsory politicalized medicine, and therefore, concealing the truth to get elected is the expedient thing to do because it's not very risky.

As you well know, gentlemen, in this connection, Senator Muskie recently, in talking to a group of liberals, let the cat out of the bag when he stated, and I quote: "Do we really expect the majority of Americans to support national health insurance when estimated costs range up to $100 billion a year?"

Mr. Woolley will later make more comments about this $100 billion figure.

Politicians, in order to conceal the truth, must affirmatively dwell on promised benefits and paint glowing pictures of utopia for those in their constituency who don't understand that you can't get something for nothing.

Further, they have to be careful that the truth is not exposed and fully appreciated by the voters about how political medicine will increase taxes; increase inflation; double the Federal budget; increase the power of the Federal bureaucracy to force employers, employees, doctors, and hospitals to fill out millions more forms; force substitution of the judgment of far-removed, impersonal, indifferent Government employees for the judgment of personally interested attending physicians or local hospitals.

Additionally, and this is very important, they have to confuse or dodge the fact that their votes will empower the bureaucracy to invade the sacred privacy of confidential communication of patients with their physicians, and that no longer will the Federal bureaucracy have to steal medical records as they did in the *Ellsberg* case, but Congress will hand this authority to them on a silver platter.

Now, let's look at the assumptions of the labor union leaders who favor compulsory politicalized medicine. These assumptions are significant assumptions that the electorate should know about.

First, union leaders assume that compulsory nationalized medicine will shift health insurance from a fringe benefit of collective bargaining to a tax-paid program, and free up corporate funds that can be grabbed by unions for higher wages without bankrupting the corporations.

They also assume that compulsory politicalized medicine paid out of taxes will release for union manipulation billions of dollars now tied up in union health and welfare programs.

Next, let's consider assumptions of insurance companies favoring compulsory politicalized medicine. They assume that Government medicine is inevitable; therefore, the salvation of health insurance companies lies in becoming the Government's fiscal agent to administer a nationalized system.

They also assume that when insurance companies are in control of political medicine, they will have won the struggle with hospitals and the medical profession for dominance over U.S. medicine. They will be on top—or they think that they will be on top.

Next, consider the assumptions of hospitals favoring compulsory politicalized medicine. They assume they must go along with Government and be willing collaborators of the Federal bureaucracy to interfere with the exercise of independent professional judgment by doctors in order to get Federal money for themselves.

They also assume that if they don't go along, the Federal Government will stop the big money flowing to the hospitals.

Next, assumptions of hospital supply and equipment companies are that when nationalized medicine becomes a reality, they can ride the multibillion-dollar Federal gravy train to riches. They also assume they can become involved with Government and retail their independence.

Now, gentlemen, both you and I know that that is a delusion; in fact, it is a delusion of grandeur.

Now, let's look at the assumptions of big business leaders favoring compulsory politicalized medicine.

First, they assume that compulsory politicalized medicine, more familiarly known as National Health Insurance will relieve corporations of the increasingly heavy burden of paying all or the lion's share of health insurance premiums. For example, the Washington Business Group on Health, a small group of professional lobbyists, recently purported to speak for a coalition of corporations and organizations such as the Health Insurance Association, and the Chamber of Commerce of the United States in advocating that "participation in a national health insurance program be mandatory for all employers with one or more employees."

Finally, let's examine the assumptions of some medical organizations that favor Government intervention. The first assumption is that compulsory politicalized medicine is inevitable and if doctors go along they will be able to control the Government system. Again, this is an illusion.

The second assumption is that the name of the game is money, and medical societies—some masquerading as foundations for medical care—may as well get their share.

These assumptions and attitudes on the part of the AMA and a number of its constituent State medical societies do not represent either the beliefs or the desires of all medical organizations. Most notably, the Association of American Physicians and Surgeons emphatically does not believe that medicine can get along by going along; it does believe that government subsidy means government control; that it is sheer naivete to believe that doctors will be able to control any part of any scheme of government medicine; it does believe that acceptance of Federal money by medical organizations is a violation of ethics and a sellout of the profession, as well as of the American people.

The assertion that socialized medicine is inevitable is a cop out, a rationalization, an excuse to justify capitulation to get Federal money.

The AAPS does not buy that "inevitability" argument.

At this time I would like to call on Mr. Frank Woolley, who will present information regarding our association's court case, and statistics regarding the previously mentioned cost of so-called national health insurance.

Mr. WOOLLEY. Thank you, Mr. Campbell.

Mr. Chairman, the AAPS has a case pending in the U.S. Supreme Court challenging the constitutionality of a law passed by Congress in 1972, popularly known as PSRO, which gives the Secretary of HEW and the bureaucrats authority to substitute their judgment for the judgment of the attending physician on what is medically necessary and appropriate for a patient. I have the brief we filed with the Supreme Court with me. I would be happy to file it with the committee if they would like to have a copy of it. It won't be necessary to put it in the record of these hearings because it is too voluminous for that record.

Mr. ROSTENKOWSKI. Without objection that will be filed in the committee office.

[The document referred to may be found in the files of the committee.]

Mr. WOOLLEY. We will not drop this case. The PSRO law is bad, and we shall do whatever we legally can to see that it is abolished.

Obviously, the assumptions Dr. Campbell just mentioned with respect to various groups who are pushing for compulsory politicalized medicine do not in any way prove that their schemes will make more and better medical care available to everyone at less cost. None of these groups is sufficiently concerned about the cost, although the dollar cost alone should be sufficient to keep any responsible person from favoring compulsory politicalized medicine.

The records of the Federal Government are clear that the schemes of political medicine in this country have been so costly that to apply them to all the citizenry would be the most irresponsible fiscal act that any legislator could perform.

What are the facts?

We have 10 years of experience with medicare and medicaid which clearly show that if such programs are applied to all the people, not only will New York be bankrupt, but the entire country will be bankrupt. If you are concerned about the effect of the financial collapse of New York City, which is the result of plunder by politicians and labor leaders, then you should be a hundred times more concerned about what total compulsory politicalized medicine would do to free institutions in this country.

Before medicare became law in 1965, the actuaries and the Secretaries of the Department of Health, Education, and Welfare, based on stacks of statistics, solemnly assumed the Congress and the public that their estimates were "conservative" and "safe," and that the first year of medicare hospitalization alone for everyone over 65 years of age would only cost $900 million. The truth is that it cost $2.7 billion. The estimates were not just 10 or 20 percent off, but 300 percent off. Medicare cost three times what the bureaucrats said it would cost.

Not only did the bureaucrats say that hospitalization alone would cost only $900 million the 1st year, but they said after the fifth year it would only cost $1.4 billion a year, and after the 10th year $1.7 billion. The truth is that the fifth year it actually cost $5.6 billion, which is four times as much as estimated. The 10th year cost is now over 10 times as much as was promised.

We are told now that the Kennedy-Corman bill, which is intended to force on the Nation complete compulsory political medicine for everyone from sperm to worm, will cost only $129 billion. Assuming that the HEW bureaucrats' estimate of costs—and this, incidentally, was the estimate of HEW—assuming that the HEW bureaucrats' estimate of costs are equally as inaccurate as their medicare estimates have proven to be, then the cost of the Kennedy-Corman bill would not be $129 billion for the 1st year, but three times that much—more nearly $387 billion; and the 10th year 10 times as much.

These billions are so horrible, unthinkable and overwhelming that only bureaucrats and politicians who are used to dealing in billions can conceive of what is being done. However, this committee should know, as should the public, that presently—according to Federal statistics—48 percent of everything everybody earns in this country is now being taken and spent by Government. In the case of medicine, according to a bulletin of the Social Security Administration, $197 is being privately spent for every person, and $297 is being spent by Government for every person. The combined per capita expenditure for medicine is, therefore, $492 at present.

Under the Kennedy-Corman bill, HEW estimates per capita expenditures would be $600 the first year. However, if allowance is made for the fact that HEW bureaucrats never have estimated the cost of any program as high as it has actually turned out to be, and if we apply the same inaccurate understatement that the HEW bureaucrats made on medicare to the Kennedy-Corman bill, the first year cost per person of that program would be $1,784.

In order to get this into focus for a family of four, consider these facts: The present combined cost of medical care taking into account governmental and private expenditures, is $1,968. HEW estimates that under the Kennedy-Corman bill it would be increased to $2,400; but again, applying the medicare inaccuracies, it would turn out to be $7,136 the first year. Consider these horrible figures with the fact that, according to the Survey of Current Business of the U.S. Department of Commerce for April 1975, the average annual earnings per worker was only $8,031.

Talk about bankruptcy. We suggest that the curtain ringing on the bankruptcy of New York City is a dire warning to every U.S.

Government elected or appointed official that the Federal Government can collapse if it, too, continues its reckless spending. Total compulsory politicalized medicine in the United States would mean destruction of our system.

However, if we are smart, we will prove that Lenin was wrong when he laid out his Machiavellian plan for destroying a private capitalist system. John Maynard Keynes understood what Lenin was up to. He said:

> Lenin was certainly right. There is no subtler, no surer means of overturning the existing basis of society than to debauch the currency. The process engages all the hidden forces of economic law on the side of destruction, and does it in a manner which not one man in a million is able to diagnose.

We have attached charts to our statement that show how inflation and Government spending is running amok, and why this plunder must stop.

Also, for the benefit of the committee, and others we have provided excerpts of the ridiculous, erroneous, misleading statements by Secretary Ribicoff made in 1961 in effect amount to fraud—statements made before the House Ways and Means Committee on H.R. 4222, the King-Anderson bill providing for health benefits in hospitals and other facilities. These statements were made when Mr. Ribicoff was trying to deceive the American people into acceptance of, and the Congress in passage of, the King-Anderson bill, which, in 1965, with many expensive "goodies" added to it, became the medicare-medicaid law. That law is now helping to bankrupt the Federal and State governments by costing $28.7 billion in 1976—which is over 15 times more than the top estimates originally promised when the legislation was considered.

This Congress, considering legislation to nationalize medicine, should not repeat the mistake made in 1965 when Congress passed the medicare-medicaid law on the basis of misrepresentations and falsehoods by the Feedral bureaucracy.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

STATEMENT OF R. LOWELL CAMPBELL, M.D., PRESIDENT, AND FRANK K. WOOLLEY, EXECUTIVE DIRECTOR, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, IN OPPOSITION TO COMPULSORY POLITICAL MEDICINE (FALSELY LABELED NATIONAL HEALTH INSURANCE)

I am R. Lowell Campbell, M.D. of Corsicana, Texas appearing as President of the *Association of American Physicians and Surgeons.* Accompanying me is Mr. Frank K. Woolley, Executive Director.

The Association is a free, independent, non-governmental voluntary organization of members of the medical profession, united for the purpose of analyzing the profession's problems and formulating actions to improve medical care for all Americans, preserve freedom of choice for patient and doctor, protect the practice of private medicine, and educate physicians and the public to recognize and defeat schemes that would weaken or destroy our free-choice system of medical care.

The proponents of compulsory politicalized medicine claim their schemes, which are deceitfully and wrongfully labeled National Health Insurance, will make more and better medical care available to everyone at less cost.

Generally, the schemes are based upon assumptions which need to be carefully considered by citizens who value individual liberty and responsibility and who understand the economic and political system of the United States which, while not perfectly operated, has made this country the most free and prosperous on earth. The primary basis of this system is that you get what you pay for in a free-choice, willing-exchange economy. It is our purpose here to bring the assumptions on which proposals for politicalized medicine are based into focus with the fundamental beliefs of most of the people in this country, who are opposed to those schemes and all other attempts to use governments to oppress individual liberty.

Most of the assumptions on which compulsory politicized medicine schemes rest would undermine our basic free-choice system, deny individual dignity and liberty and set our free-choice political and economic system on a collision course with tyrannical totalitarianism, and thus put basic policies of government into conflict wtih the fundamental beliefs of its citizens. Yet, most Americans have thought that opposing the tyranny of totalitarianism was what World War II was all about and that our military efforts against the communists since then have been for the same purpose. The question the American people need to answer is: "Are we now to blindly embrace schemes of totalitarianism in medicine and delude ourselves that we are making a free choice because the interventionists try to confine the arguments to 'who does the dictating and controlling and how' and not whether we want these schemes in the first place."

We will look at the assumptions of the proponents of these schemes from various fundamental points of view. The assumption of the bureaucrats; politicians; labor union leaders; big business leaders; insurance companies; hospital supply and equipment companies; and finally, medical organizations.

It should be clear that I am not talking about any group that are opposed to compulsory politicalized medicine but only those that are for it.

ASSUMPTIONS BY BUREAUCRATS FAVORING COMPULSORY POLITICALIZED MEDICINE

Bureaucrats are infallible or, at least, so far superior to ordinary patients, doctors and hospital employees that all citizens should have a part of their earnings forceably taken from them and spent for them by bureaucrats because that way they will get "more appropriate and necessary medical care at reasonable cost." (See Public Law 92–603 and Regulations of HEW issued pursuant thereto.)

The States of the Union have no independent authority under the United States Constitution which cannot be pre-empted by federal employees by the devices of taxation, subsidy and control. (See speech of Madam Perkins in 1962 to HEW employees in which she tells how they struck upon the device of getting around the constitutional division of power between the states and the United States government by using the taxing power—*The Roots of Social Security.*)

Congress is an inferior branch of government to be manipulated by the executive; the Constitution and courts are annoyances that must be "mitigated or removed," and the bureaucracy exists to control citizens, not to serve them—in fact, to mold citizens' behavior as bureaucrats deem appropriate. (See *The Evolution of Medicare . . . from Idea to Law*—HEW 1969; and see Senate Labor and Public Welfare Committee Report on Kennedy Bill S1466 on Health Education and Communicable Diseases. Also, see the 1972 Brookings Institution Report, *Setting National Priorities, the 1973 Budget,* particularly Chapter 15 on "A New Approach to Priorities" in which it is said: "Satisfying these new concerns requires finding ways of changing the behavior of individuals and institutions.")

The bureaucracy has the right and duty to usurp the legislative function through the promulgation of regulations which exceed legislative intent and which are couched in such ambigious and tricky language that the courts are repelled from trying to unravel the Machiavellian consequences.

City and state governments can be easily bought and controlled by getting them hooked on federal money and dictating to them what they must do to keep from losing it. (This is so self-evident that no recitation of examples is required.)

Bureaucrats should help labor union leaders, ex-politicians and academicians in manipulating and rigging elections of those congressmen who favor more spending and more power for the bureaucracy. (See proposed bills to remove limitation on 2.5 million federal employees from participating in electioneering. Also see bills to unionize postal employees and HMO legislation and supporting arguments for giving control of medical care to labor union leaders.)

Bureaucrats are more capable of deciding what is medically necessary and appropriate for individual Americans than doctors.

Ordinary law-abiding citizens who are competent to vote and make choices among competing candidates for public office are to be considered incompetent to make proper choices for their own medical care in a free market and, therefore, should be denied the right to choose where, when, how and by whom they should be treated.

There is a definable need for medical care that government can identify and provide at reasonable cost and satisfaction to patients if only obstinate physicians would subordinate themselves to dictation and control mechanisms devised and operated by a centralized bureaucracy.

Every facet of life in the United States will be improved if regulated and controlled by federal bureaucrats.

Underlying all these assumptions is the basic assumption that bureaucrats have a right above the Constitution to do *all* these things.

ASSUMPTIONS BY POLITICIANS FAVORING COMPULSORY POLITICALIZED MEDICINE

If they promise to vote for medical care for everyone paid out of the federal treasury, they will, on balance, gain votes for election or re-election.

Socialized medicine won't lead to socialized anything else.

The American people are gullible enough to believe anything a politician tells them—especially if they are told they're going to get something for nothing.

The American people are really not bright enough to figure out the truth about compulsory politicalized medicine and, therefore, concealing the truth to get elected is the expedient thing to do because it's not very risky.

These politicians, in order to conceal the truth, must affirmatively dwell on promised benefits and paint glowing pictures of Utopia *for* those in their constituency who don't understand that you can't get something for nothing. Politicians also skirt the truth to avoid responsibility for the injury their actions will inflict on their constituents. For example, they will have to slip, slide and duck to avoid the truth about the terrible cost not only in money but in the deterioration in quality of medical care and in undermining the right of citizens to freely choose their doctor or hospital. Above all, they must avoid letting anybody know that they realize that by using federal power to deny citizens the right to choose their doctor or hospital, the precedent is being set to deny them the right of free choice of housing, clothing, food, recreation, transportation, and everything else.

Further, they will have to be careful that the truth is not exposed and fully appreciated by the voters about how political medicine will increase taxes; increase inflation; double the federal budget; increase the power of the federal bureaucracy to force employers, employees, doctors and hospitals to fill out millions more forms; force substitution of the judgment of far-removed, impersonal, indifferent government employees for the judgment of personally interested attending physicians or local hospitals. Additionally, they will have to confuse or dodge the fact that their votes will empower the bureaucracy to invade the sacred privacy of confidential communication of patients with their physicians and that no longer will the federal bureaucracy have to steal medical records as they did in the Ellsburg case, but Congress will hand this authority to them on a silver platter.

Not only will they carefully slide away from the truth about the additional thievery of government through taxes and inflation but, if need be, they will be prepared to hide that and other truths by trying to discredit the medical profession by attacking the doctors' lobby as being selfish and greedy. Those who are well schooled in the tactics of British Fabian Socialists and their American offspring, members of the League for Industrial Democracy, may copy the vicious attack on doctors by George Bernard Shaw in his 1906 book *The Doctor's Dilemma* which helped pave the way for so-called National Health Insurance in Britain in 1911. Others may use the tactic of Aneurin Bevan, British labor leader who forced the National Health Service through parliament in 1947, who would ask the coal miners: "Who is the fellow in the village who drives the Rolls Royce?" Of course, since labor union leaders have been the primary driving force in America in providing financing and manpower in recent elections, many politicians will be seeking to curry favor with labor union leaders, the overwhelming majority of whom favor politicalized medicine without regard to what such action may mean in destroying the American free-choice system.

Unfortunately, too many members of Congress either are willing collaborators in the freedom-zapping schemes of the bureaucracy, or beholden to labor bosses who could care less about the constitutional rights of patients and doctors (even though union members are patients) or are so mesmerized by the slippery semantics and political power of bureaucrats and labor bosses they can't see and won't admit the danger to individual liberty in these schemes.

ASSUMPTIONS OF LABOR UNION LEADERS FAVORING COMPULSORY POLITICALIZED MEDICINE

Socialized medicine is a big step toward a socialist government and when that is achieved, labor leaders will call governments tune—in fact will *be* the government.

Compulsory nationalized medicine will shift health insurance from a fringe benefit of collective bargaining to a tax paid program and free up corporate funds that can be grabbed by unions for higher wages without bankrupting the corporations.

Compulsory politicalized medicine paid out of taxes will release for union manipulation billions of dollars now tied up in union health and welfare programs.

Corporate profits are becoming less and less available as a source of insatiable union demands for ever increasing wages and benefits for ever lessening productivity. Between inordinate union demands and oppressive federal laws and regulations, such as OSHA, and increased taxes on corporations (direct and through inflation), corporate profits after taxes have been stomped down until they now total less than half the amount of money being spent by a single agency of government—the Department of Health, Education and Welfare. Of course some labor union leaders who apparently want to bring about the dictatorship of the proletariat as rapidly as possible would not be interested in saving any corporation from bankruptcy, or the U.S. government either, for that matter.

ASSUMPTIONS OF INSURANCE COMPANIES FAVORING COMPULSORY POLITICALIZED MEDICINE

Government medicine is inevitable; therefore the salvation of health insurance companies lies in becoming the government's fiscal agent to administer a nationalized system.

When insurance companies are in control of political medicine they will have won the struggle with hospitals and the medical profession for dominance over U.S. medicine. They will be on top.

Blue Cross and Blue Shield, the latter having grown powerful enough to become independent of the medical profession, vigorously maneuvered to become agents of government to carry out and exercise the controls inherent in Medicare and Medicaid. Some of their leaders are so attuned to the government take-over of their business that they are promoted at every turn by the bureaucracy and, in turn, they prate the collectivist line. For example, Walter McNerney of Blue Cross says that health care is no longer an individual responsibility but is a community affair (pure pro-collectivism and anti-individualism). Over the past few years, Blue Cross has had a decreasing percentage of the market for health care insurance.

ASSUMPTIONS OF HOSPITALS FAVORING COMPULSORY POLITICALIZED MEDICINE

They must go along with government and be willing collaborators of the federal bureaucracy to interfere with the exercises of independent professional judgment by doctors in order to get federal money for themselves.

If they don't go along, the federal government will stop the easy money flowing to the hospitals.

Collaborating is the way to achieve a higher place in the pecking order over the physicians.

ASSUMPTIONS OF HOSPITAL SUPPLY AND EQUIPMENT COMPANIES

When nationalized medicine becomes a reality, they can ride the multibillion dollar federal gravy train to riches.

They can become involved with government and retain their independence.

These companies willingly promote government intervention because they can see dollar signs everywhere for selling a huge array of electronic and other equipment to a great new bureaucracy that will always hasten to spend the last dollar of its appropriations before the end of the fiscal year. They see fully politicalized medicine as the mammoth pot of gold at the end of the rainbow. It will be an illusion, they will find government dictating how they conduct their business.

ASSUMPTIONS OF BIG BUSINESS LEADERS IN FAVOR OF COMPULSORY POLITICALIZED MEDICINE

Compulsory politicalized medicine (more familiarly though falsely known as National Health Insurance) will relieve businesses and corporations of the increasingly heavy burden of paying all or the lion's share of heatlh insurance premiums.

The tax burden will not be as heavy as health insurance premiums because the tax for government health care will be spread all across the economy.

Medicine, even if it is a profession, shouldn't be immune from the bureaucratic controls and regulations that business has suffered under more and more in recent years.

Those business leaders whose companies have been enjoying lush federal government contracts tend to flirt with endorsement of compulsory politicalized medicine either through fear of bureaucrats who manipulate these contracts or because they can no longer see anything wrong with the controls that go along with being bankrolled by government. This is indeed a dangerous game—helping government use its power to plunder the people, with no thought of the consequences to the plundered, that is, the taxpayer and inflation payer.

In this respect, such business leaders are no different than labor leaders who are gouging the public (including their own union members) with total indifference to the damage they do to the economic system and to the rights of individuals. Thoughtful citizens recognize, incidentally, that union membership constitutes only 25 per cent of the labor force and that a huge amount of business is carried on by small businesses outside the direct control of the big corporations that are unionized and have adopted the policy of capitulation to the bureaucracy—go along to get along.

ASSUMPTIONS OF SOME MEDICAL ORGANIZATIONS FAVORING GOVERNMENT INTERVENTION

Compulsory politicalized medicine is inevitable.

If doctors go along, they will be able to control a government system.

The name of the game is money and medical societies may as well get their share.

Government subsidy doesn't necessarily mean government control.

Since socialized medicine is inevitable, medicine needs to push its own proposal to preserve as much freedom as possible.

These assumptions and attitudes on the part of the AMA and a number of constituent state medical societies do not represent either the beliefs or the desires of all medical organizations. Most notably, the *Association of American Physicians and Surgeons* emphatically *does not* believe medicine can get along by going along; it *does* believe government subsidy is government control and it is sheer naivete to believe doctors will be able to control any part of any scheme of government medicine; it *does* believe that acceptance of federal money by medical organizations is a violation of ethics and a sellout of the profession as well as the American people.

The statement that socialized medicine is inevitable is a cop out, a rationalization, an excuse to justify capitulation to get federal money.

The AAPS does not buy that inevitability argument. The APPS has a case pending in the United States Supreme Court challenging the constitutionality of a law passed by Congress in 1972, popularly known as PSRO, which gives the Secretary of HEW and the bureaucrats authority to substitute their judgment for the judgment of the attending physician on what is medically necessary and appropriate for a patient.

We will not drop this case regardless of who proposes not to put it into operation. The law is bad and we shall do whatever we legally can to see that it is abolished.

Some medical organizations, particularly those who have attorneys who are simultaneously attorneys for the hospital association, Blue Cross, Blue Shield, and the state licensing board, do not want to do anything to rock the boat so they counsel to go along with nationalized medicine—never admitting that they are profiting by the deal.

Obviously, these assumptions by these various groups who are pushing for compulsory politicalized medicine do not in any way prove that their schemes will make more and better medical care available to everyone at less cost. None of these groups is sufficiently concerned about the cost, although the dollar cost alone should be sufficient to keep any responsible person from favoring compulsory politicalized medicine.

What are the costs? Every bit of information available from foreign countries where politicalized medicine has been imposed and in this country show that the costs are unconscionable. The most objective study that has been done on the costs in foreign countries is contained in the book *Medicine and the State* by Lynch and Raphael. This Association is publishing and distributing this book and copies will be made available to the Committee upon request.

The records of the federal government are clear that the schemes of political medicine in this country have been so costly that to apply them to all the citizenry would be the most irresponsible fiscal act that any legislator could perform.

What are the facts?

We have ten years of experience with Medicare and Medicaid which clearly shows that if such programs are applied to all the people not only will New York be bankrupt but the entire country will be bankrupt. If you are concerned about the effect of the financial collapse of New York City, which is the result of plunder by politicians and labor leaders, then you had better be a hundred times more concerned about what total compulsory politicalized medicine will do to free institutions in this country.

Before Medicare was made law in 1965, the actuaries and the Secretary of the Department of Health, Education, and Welfare, based on stacks of statistics, solemnly assured the Congress and the public that their estimates were "conservative" and "safe" and that the first year of Medicare hospitalization alone for everyone over 65 years of age would only cost $900 million. (See testimony of HEW Sec. Abraham Ribicoff, July 24, 1961.) The truth is that it cost $2.7 billion—three times what the bureaucrats said it would cost. Congressman Bruce Alger of Texas and spokesmen for doctors in the practice of private medicine tried to get the Congress and the public to understand through hearings before the House Ways and Means Committee that the HEW estimates were completely untrue. This advice was ignored and unconscionable plunder resulted.

Not only did the bureaucrats say that hospitalization alone would cost only $900 million the first year, but they said after the fifth year it would only cost $1.4 billion a year and after the tenth year $1.7 billion. The truth is that the fifth year it actually cost $5.6 billion, which is four times as much as estimated. The tenth year cost is now over ten times as much as the politicians promised.

We are told now that the Kennedy-Corman bill, which is intended to force on the nation complete compulsory political medicine for everyone from sperm to worm, will cost only $129 billion. (See testimony on HEW Sec. Caspar Weinberger, July 1974.) Assuming that the HEW bureaucrats' estimate of costs are equally as inaccurate as their Medicare estimates have proven to be, then the cost would not be $129 billion for the first year but three times that much, more nearly $387 billion; and the tenth year ten times as much. Bear in mind the fact government with all of its wild, irresponsible, reckless fiscal policies is spending only about $300 billion. If this program is put into effect, it would be spending the first year $387 billion for medical care alone. These billions are so horrible, unthinkable and overwhelming that only bureaucrats and politicians who are used to dealing in billions can remotely conceive of what is being done. However, this Committee should know, as should the public, that presently 48%

of everything everybody earns in this country is now being taken and spent by government. In the case of medicine, according to a Bulletin of the Social Security Administration, $197 is being privately spent for every person and $297 is being spent for every person by government. The combined per capita expenditure for medicine is, therefore, $492 at present. Under the Kennedy-Corman bill, HEW estimates per capita expenditures would be $600 the first year. However, if allowance is made for the fact that HEW bureaucrats never have estimated the cost of any program as high as it has actually turned out to be and we apply the same inaccurate understatement of the HEW bureaucrats on Medicare to the Kennedy-Corman bill, the first year cost per person of that program would be $1,784 and the tenth year cost would be $3,154 per person.

In order to get this into focus for a family of four, consider these facts: the present combined cost of medical care taking into account governmental and private expenditures, is $1,968. HEW estimates that under the Kennedy-Corman bill it would be increased to $2,400, but again applying the Medicare inaccuracies it would turn out to be $7,136 the first year, and $12,616 the tenth year. Consider these horrible figures with the fact that according to the *Survey of Current Business* of the United States Department of Commerce for April, 1975, the average annual earnings per workers was only $8,031.

Harry Hopkins, of New Deal fame, is credited with the completely irresponsible and cynical political philosophy of "spend and spend, tax and tax, elect and elect." Other equally cynical and rapacious public figures have said "the voters won't shoot Santa Claus."

We suggest that the curtain ringing down on the bankruptcy of New York City is a dire warning to every United States government elected or appointed official that the federal government can collapse if it too continues its reckless spending. Total compulsory politicalized medicine in the United States means destruction of our system.

However, if we are smart we will prove that Lenin was wrong as far as this country is concerned when he laid out his Machiavellian plan for destroying a private capitalist system. John Maynard Keynes, in 1919, in his book *The Economic Consequences of the Peace* beginning on page 235, commented about Lenin's plan for destroying private capitalism. Although John Maynard Keynes' disciples have helped get us into the tragic financial plight of the present day, he understood what Lenin was up to. He said: "Lenin was certainly right. There is no subtler, no surer means of over-turning the existing basis of society than to debauch the currency. The process engages all the hidden forces of economic law on the side of destruction, and does it in a manner which not one man in a million is able to diagnose."

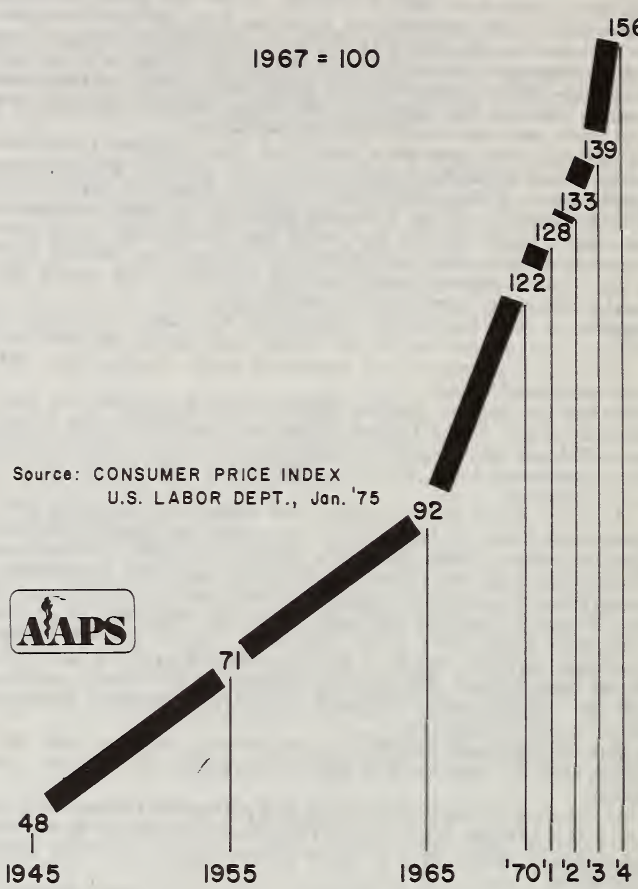
It can be that the electorate in 1976 will prove to be smarter than the politicians who think that all they have to do is expropriate the income of all this country's citizens.

Attached are charts showing how inflation and government spending is running amuck and why this plunder must stop if this country is not to be destroyed by false leaders, some of whom have to have someone else take their college examinations for them.

Also attached are the ridiculous, erroneous, misleading statements by Secretary Ribicoff made in 1961 which in effect amount to fraud—statements made before the House Ways and Means Committee on H.R. 4222, the King-Anderson bill providing for health benefits in hospitals and other facilities. This occurred when Mr. Ribicoff was trying to deceive the American people to accept and the Congress to pass the King-Anderson bill, which, in 1965, with many expensive "goodies" added to it, became the Medicare-Mecicaid Law. That Law is now helping to bankrupt the federal and state governments by costing $28.7 billion in 1976, which is over fifteen times more than the top estimates originally promised. (See attached Appendix III re current Medicare-Medicaid costs.)

Congress, considering legislation to nationalize medicine, is about to repeat the mistake it made in 1965 when it passed the Medicare-Medicaid Law on the basis of misrepresentations and falsehoods by the federal bureaucracy.

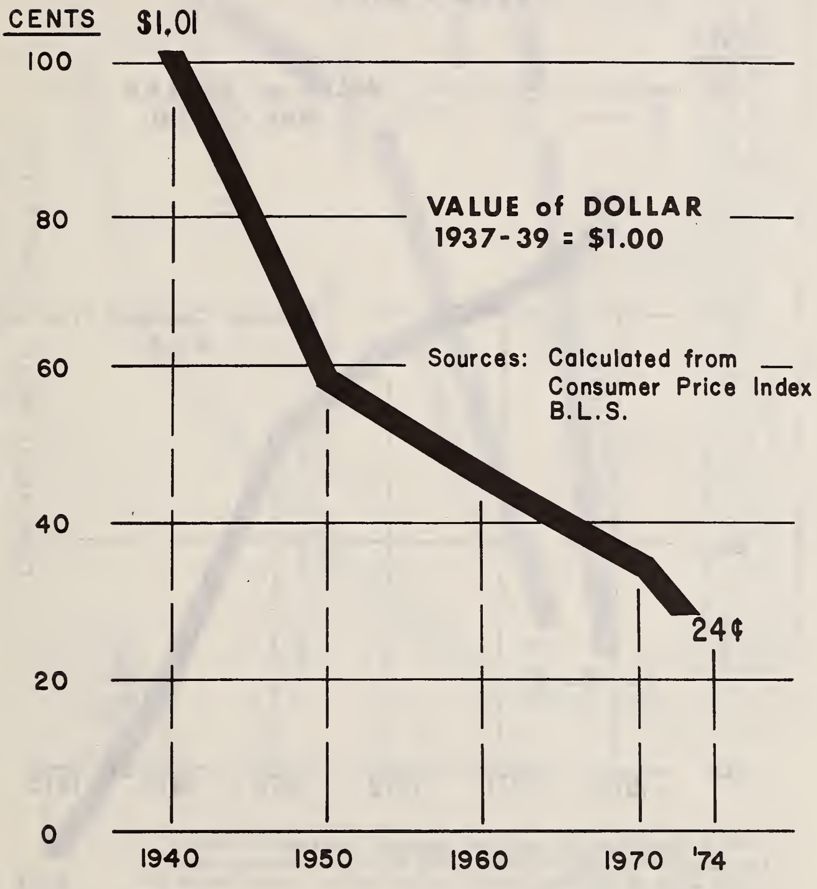
INFLATION



"This chart shows that the inflation index has risen over three times since 1945 -- from 48 to 156. Though this thermometer reading of the body politic may not be fully understood by all, the next chart brings into sharp focus the 'long view of legalized thievery' that has been going on since 1940."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

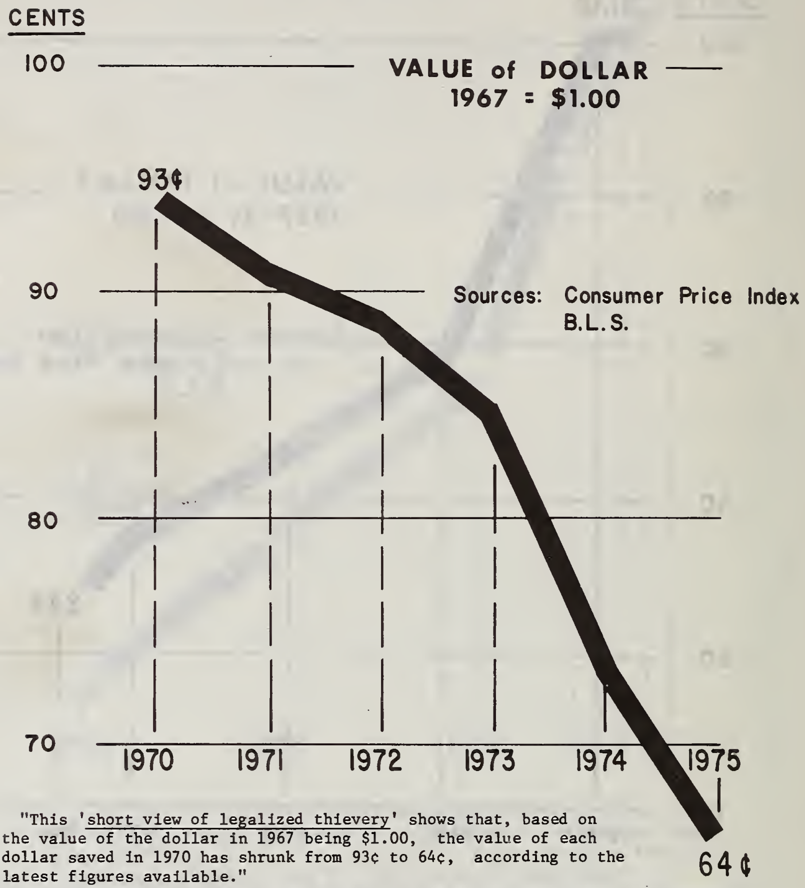
Long View of LEGALIZED THIEVERY



"This chart shows that the value of the dollar has shrunk from a 1940 value of $1.01 to 24¢ in 1974. This means to the elderly and disabled that from every $1.01 saved in 1940, 3/4 of the value of these savings has been stolen by inflation."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

Short View of LEGALIZED THIEVERY

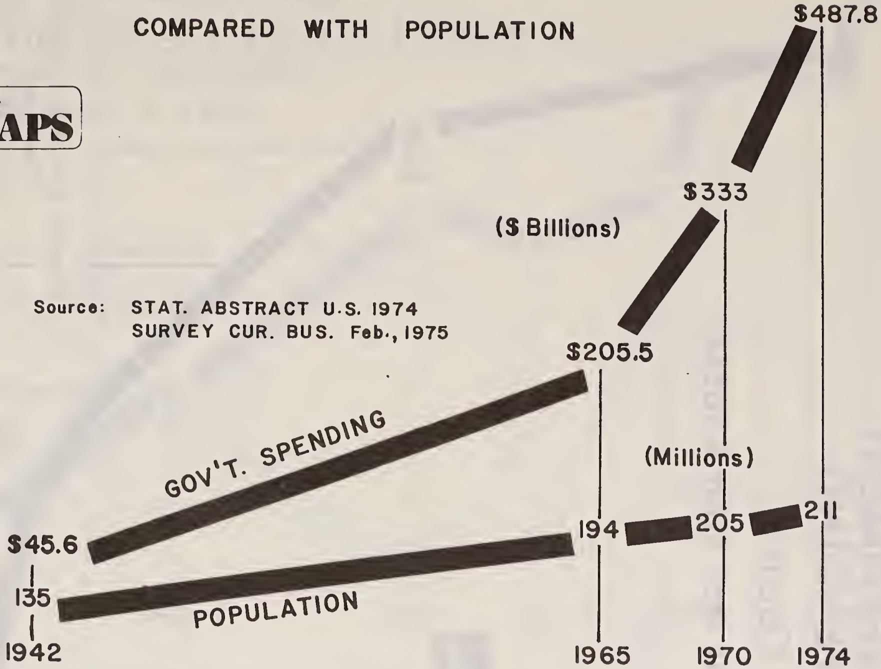


Sources: Consumer Price Index
B.L.S.

"This 'short view of legalized thievery' shows that, based on the value of the dollar in 1967 being $1.00, the value of each dollar saved in 1970 has shrunk from 93¢ to 64¢, according to the latest figures available."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

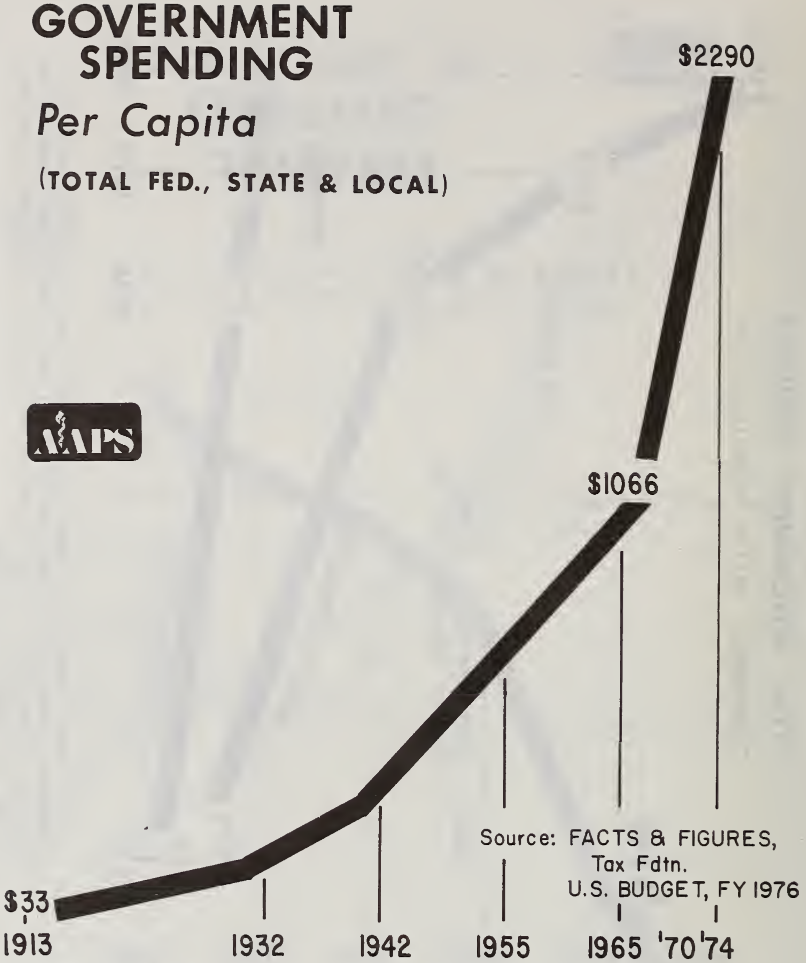
TOTAL GOVERNMENT SPENDING COMPARED WITH POPULATION



Source: STAT. ABSTRACT U.S. 1974
SURVEY CUR. BUS. Feb., 1975

"This chart compares government spending with population, and shows that government spending increased from $45.6 billion in 1942 when the population was only 135 million to $487.8 billion in 1974 when the population was estimated to be about 211 million."

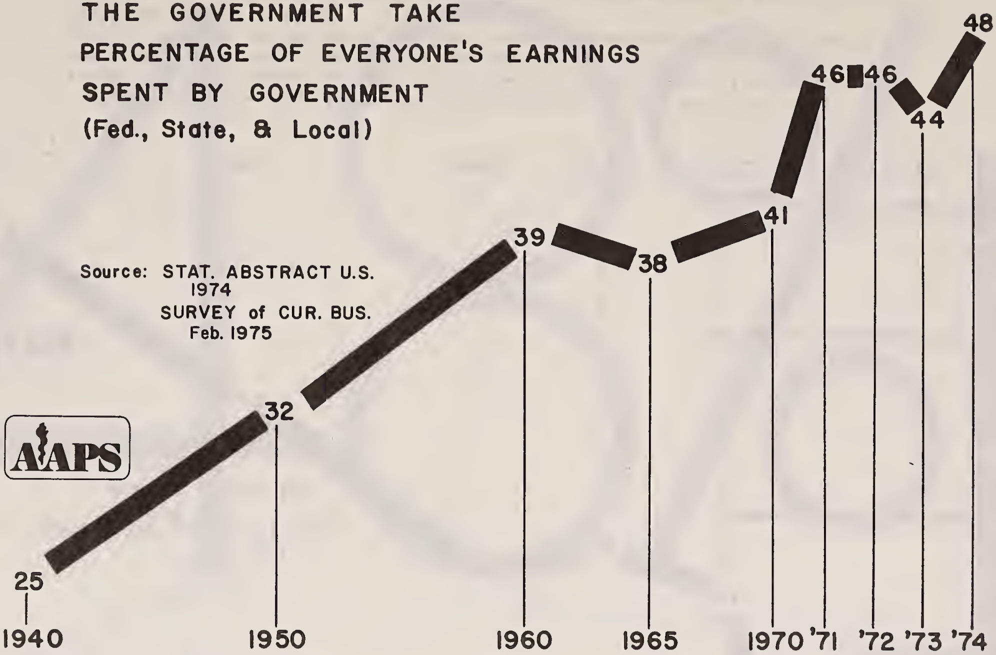
-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75



Source: FACTS & FIGURES, Tax Fdtn. U.S. BUDGET, FY 1976

"This chart shows how government spending per capita -- federal, state and local -- went up from $33.00 per person in 1913 to $1,066 per person in 1965; and then on up to $2,290 per person in 1974. The enormity of government spending is emphasized by per-family figures -- multiplying $2,290 x 4 shows that annual government spending per family is now over $9,000!"

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75



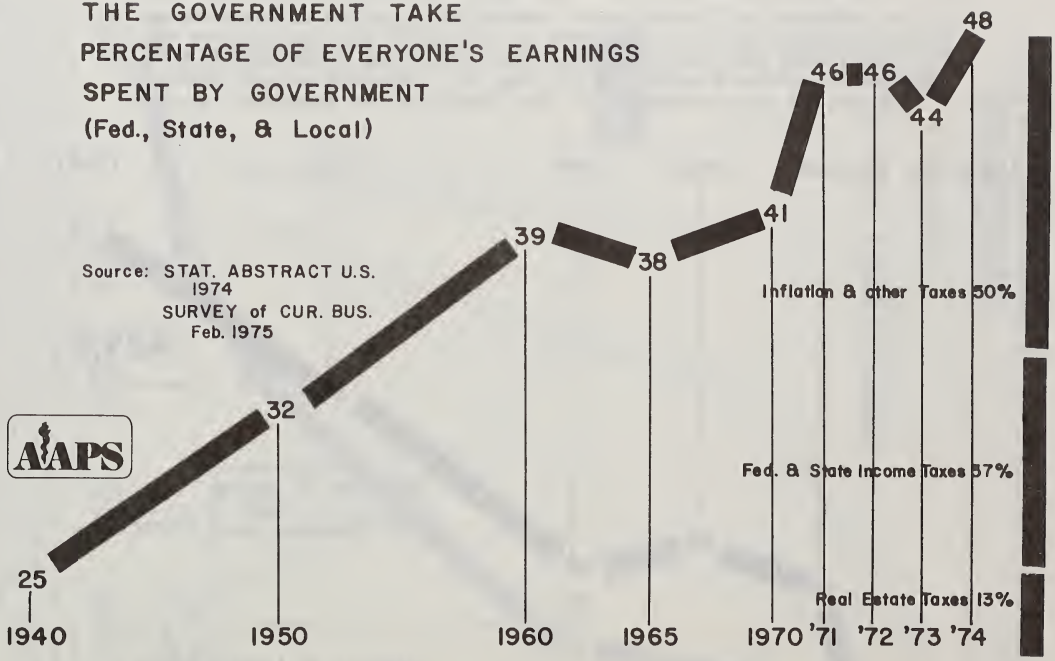
THE GOVERNMENT TAKE
PERCENTAGE OF EVERYONE'S EARNINGS
SPENT BY GOVERNMENT
(Fed., State, & Local)

Source: STAT. ABSTRACT U.S. 1974
SURVEY of CUR. BUS. Feb. 1975

"This chart shows the 'government take' -- the percentage of everyone's earnings spent by government. In 1940, 25% of everything everyone earned was spent by government. But by 1974, the 'government take' had risen to 48%! Some may find this hard to believe, for such facts are often clouded by deceit, misrepresentation and deliberate schemes to keep people from realizing the truth."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

THE GOVERNMENT TAKE
PERCENTAGE OF EVERYONE'S EARNINGS SPENT BY GOVERNMENT
(Fed., State, & Local)



Source: STAT. ABSTRACT U.S. 1974
SURVEY of CUR. BUS. Feb. 1975

"This chart shows that 13% of the 'government take' came from real estate taxes, 37% from federal and state income taxes, and the balance from inflation and other taxes. While the federal and state income taxes of the average person amounts to about 18% or 19% of his total income, when other taxes are added in the total amounts to 48%."

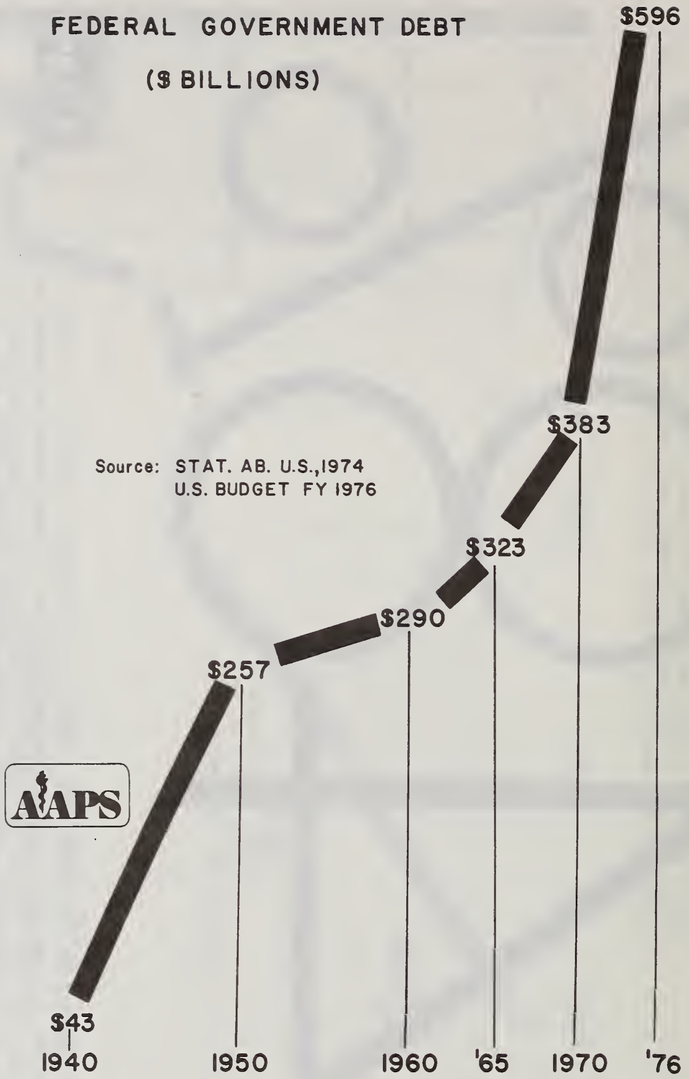
-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

48%

AAPS

"This emphasizes the important point that 'government take' is now 48%! Data in the Survey of Current Business of the U. S. Department of Commerce -- cutting through all the red tape and confusion about authorizations, outlays, trust funds and other minutia connected with government red tape -- shows clearly that government spends 48% of the total earnings of everyone."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75



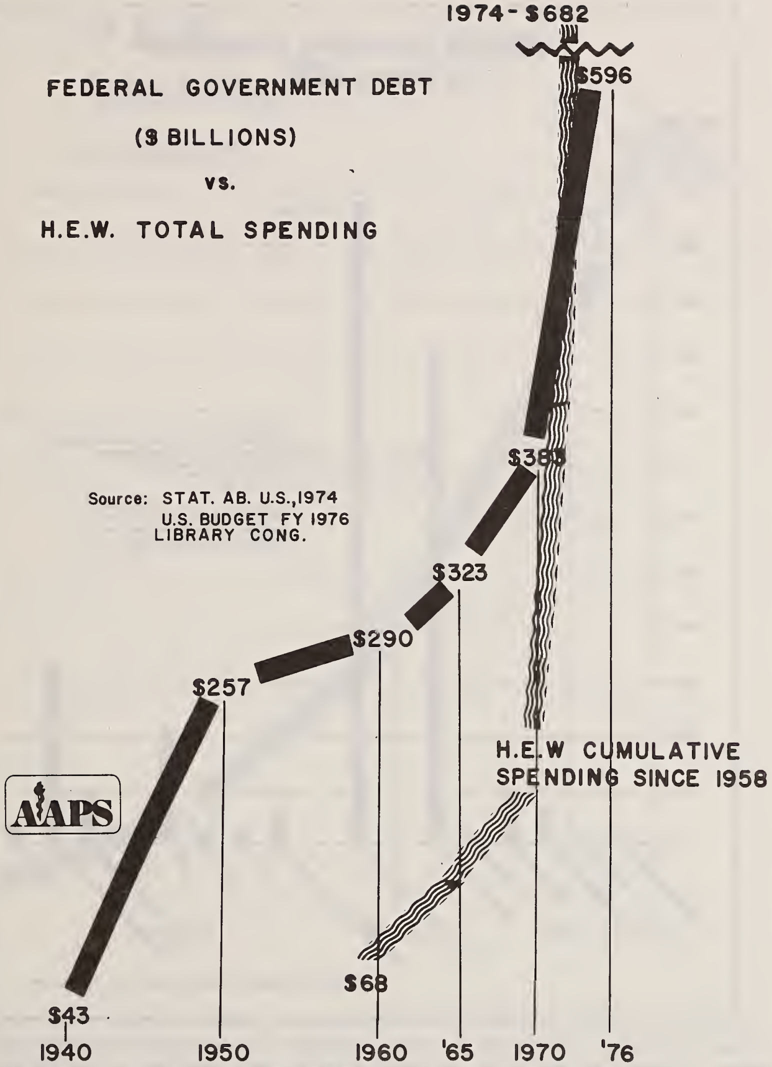
FEDERAL GOVERNMENT DEBT

($ BILLIONS)

Source: STAT. AB. U.S.,1974
U.S. BUDGET FY 1976

"This chart shows that wild government spending has increased the public debt from $43 billion in 1940 to $596 billion in 1976. The Secretary of Treasury says the federal government will have to borrow $70 billion in this fiscal year, and may have to borrow $86 billion more in fiscal 1976. This will mean that the government can do only one thing: run the printing presses!"

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75



FEDERAL GOVERNMENT DEBT

($ BILLIONS)

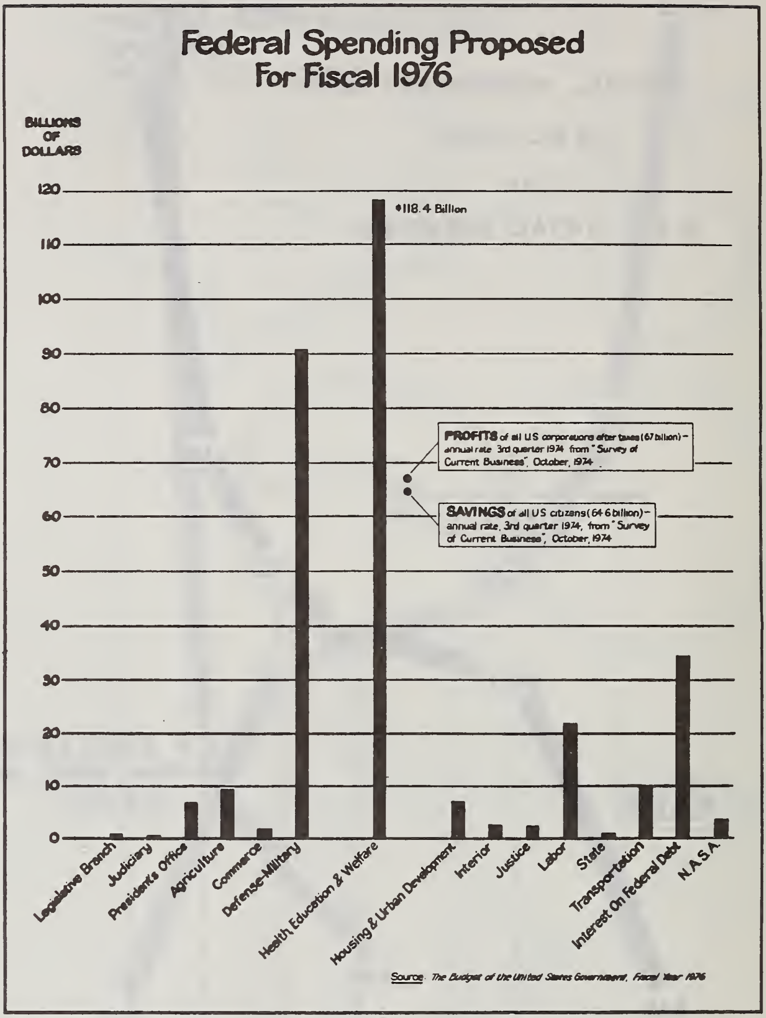
VS.

H.E.W. TOTAL SPENDING

Source: STAT. AB. U.S.,1974
U.S. BUDGET FY 1976
LIBRARY CONG.

"This chart shows that the cumulative spending of HEW since 1954 is $682 billion. This is $86 billion more than the total indebtedness of the United States. This means that HEW has spent $3,232 per person for every man, woman and child in the United States -- more than $12,000 for every family of four. The HEW cumulative-spending curve now stands almost vertical!"

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75



Federal Spending Proposed For Fiscal 1976

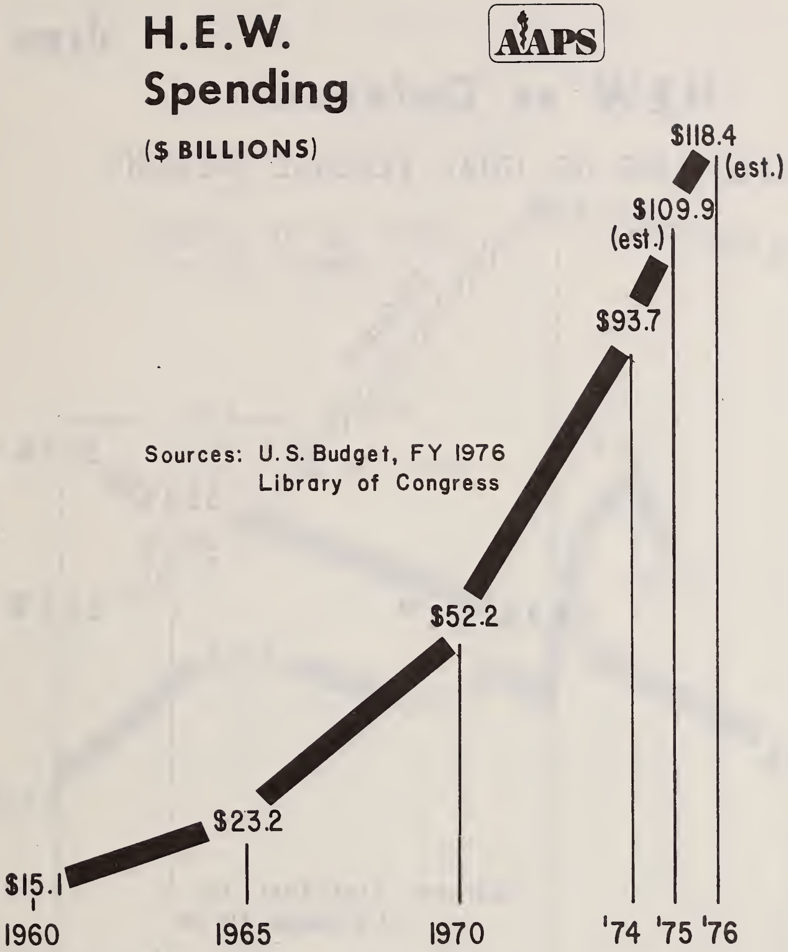
PROFITS of all US corporations after taxes (67 billion) – annual rate 3rd quarter 1974 from "Survey of Current Business", October, 1974

SAVINGS of all US citizens (64 6 billion) – annual rate, 3rd quarter 1974, from "Survey of Current Business", October, 1974

Source. *The Budget of the United States Government, Fiscal Year 1976*

"This chart shows the enormity of HEW spending in relationship to spending for defense, interest on the debt, the space program, and other major departments; and that HEW spending is almost double the $64.6 billion annual rate of savings of all citizens reported in Oct. 1974. Obviously, HEW can continue its unbridled spending only through use of printing-press money."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75



H.E.W. Spending

($ BILLIONS)

Sources: U.S. Budget, FY 1976
Library of Congress

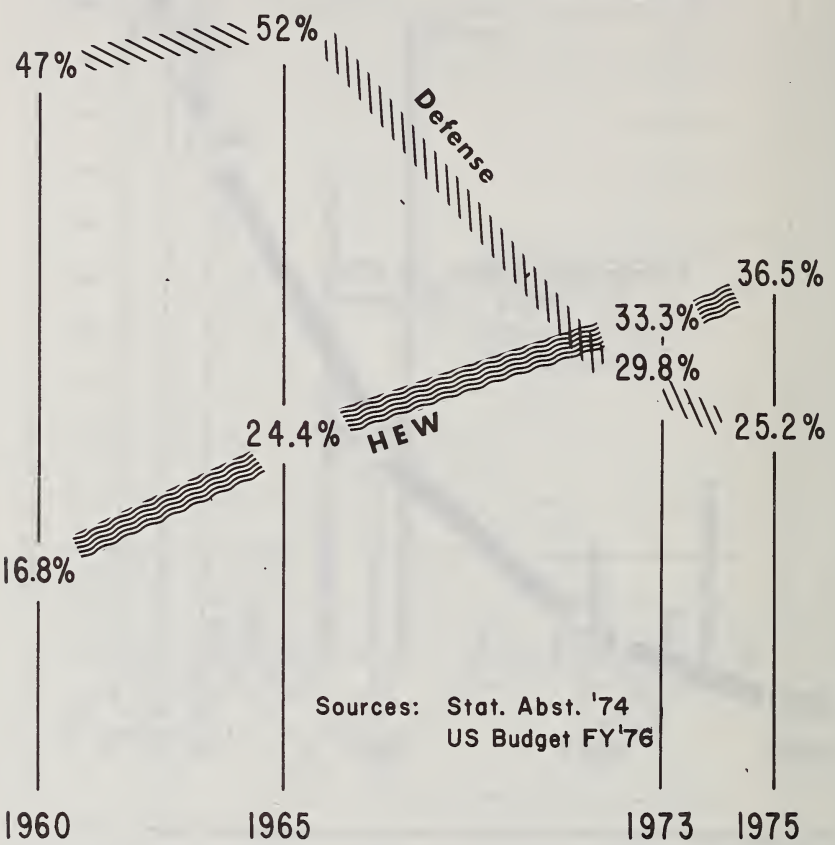
"This chart shows that HEW spending has gone from $23.2 billion in 1965 to $118 billion in 1976."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

AAPS

HEW vs Defense

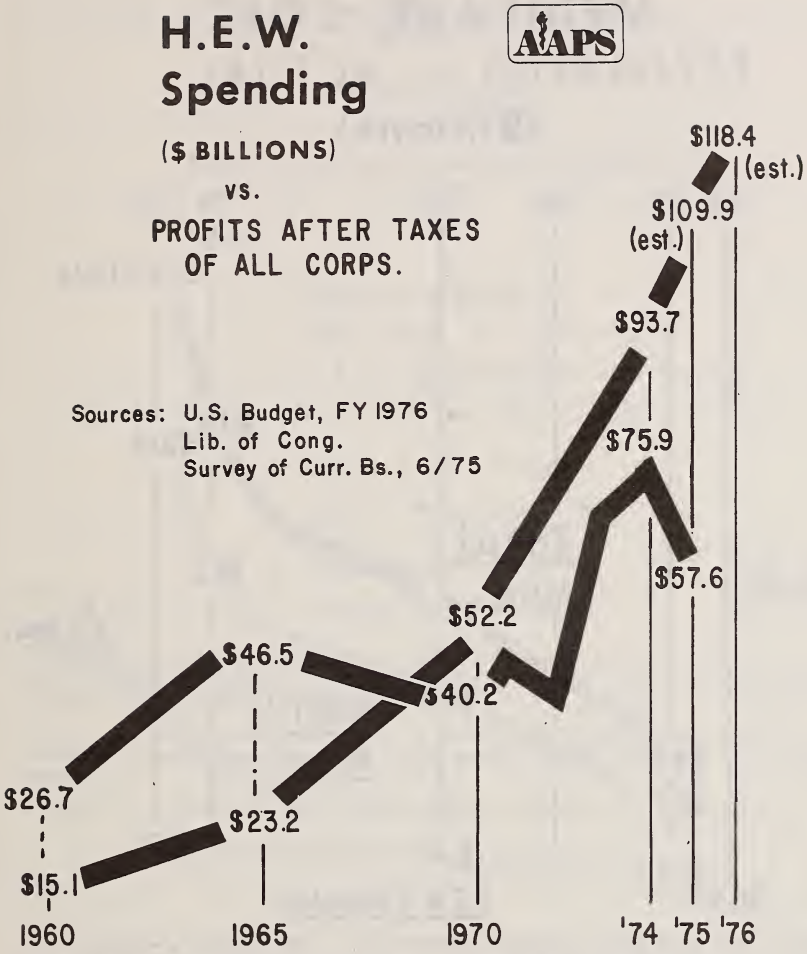
PERCENTAGE OF TOTAL FEDERAL SPENDING



Sources: Stat. Abst. '74
US Budget FY'76

"This chart shows HEW spending in relationship to spending for defense. In 1960, 47% of all federal spending was for defense, and only 16.8 was for HEW. Now, HEW spending is 36.5% of total federal spending, and defense spending is less than 25%."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75



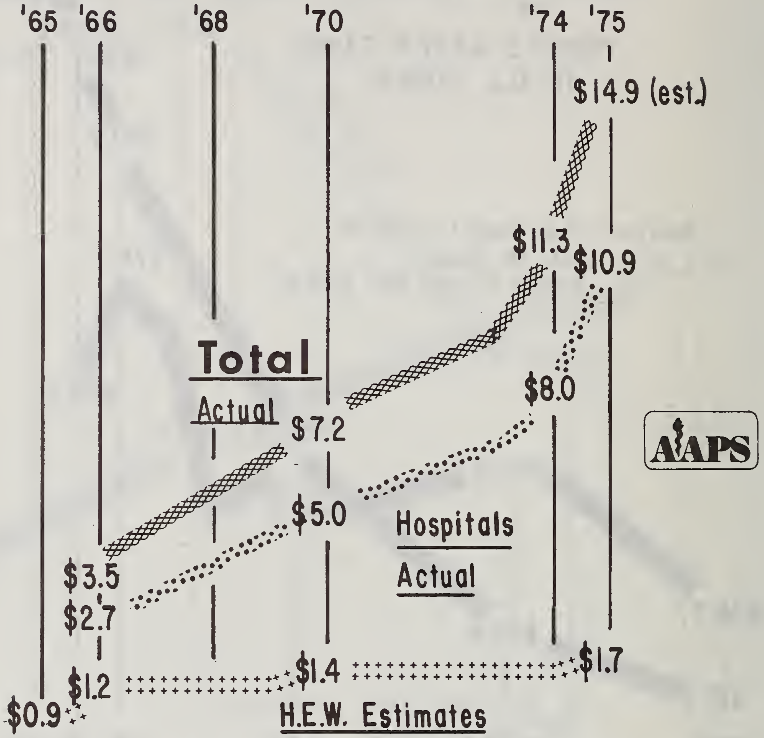
H.E.W. Spending ($ BILLIONS) vs. PROFITS AFTER TAXES OF ALL CORPS.

Sources: U.S. Budget, FY 1976
Lib. of Cong.
Survey of Curr. Bs., 6/75

"This chart shows that in 1960, profits after taxes of all corporations in the United States were $26.7 billion, and that HEW spending was much less. But in 1974, HEW spent more than all the profits after taxes of all corporations. In other words, if all the income of all corporations were confiscated -- this amount would not now pay for HEW spending.

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

MEDICARE COST
ESTIMATED v ACTUAL
(Billions)



"This chart shows that in estimating Medicare costs, HEW actuaries promised on a pile of statistics that in the first year of operation, it would cost only $900 million -- and that the cost would gradually go up to $1.7 billion in 1975.

"While there were strong objections by doctors and others to the acceptance of these HEW Medicare-cost estimates, Congress at that time apparently did not see through the misrepresentations and chicanery of the bureaucracy, and irresponsibly chose to believe the bureaucratic sooth-sayers who had an interest in betraying the people.

"Actual hospital costs the first year were more than double the amount HEW promised, and are now $10.9 billion per year. When supplemental medical program costs are added, total annual Medicare costs are now estimated at $14.9 billion."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

MEDICARE COSTS

(HOSPITAL)

Estimated v Actual

Actual in 1974 was 6 times the estimated cost

Sources:

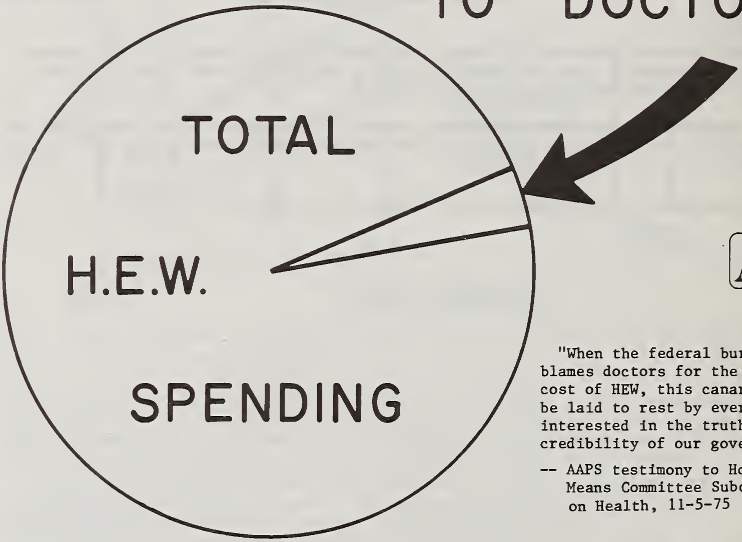
1. Actuarial Study No. 57
   SSA - H.E.W. July 1963, page 25
   W & M hearings medical care for aged
   HR 3920, Nov. 1963, p. 197
2. Budget of U.S., FY 1975
   Special Analysis page 148
3. Budget of U.S., FY 1976
   Special Analysis page 183

"Comparing the Medicare-cost estimates of HEW with the actual costs in 1974, actual hospital costs were 6 times the promised costs -- and actual total costs were nearly 9 times the cost estimates of HEW!

"These comparisons should be significant to members of Congress in evaluating HEW cost estimates of pending proposals for so-called national health insurance -- and related schemes."*

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

PERCENTAGE OF PAYMENTS TO DOCTORS FOR MEDICARE AND MEDICAID OUT OF TOTAL H.E.W. SPENDING



AAPS

"When the federal bureaucracy blames doctors for the increased cost of HEW, this canard should be laid to rest by every person interested in the truth and the credibility of our government."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

TOTAL H.E.W. SPENDING FOR 1974 = $ 97 BILLION

AAPS

PAYMENTS TO DOCTORS IN 1974:

FOR MEDICARE = $ 2.595

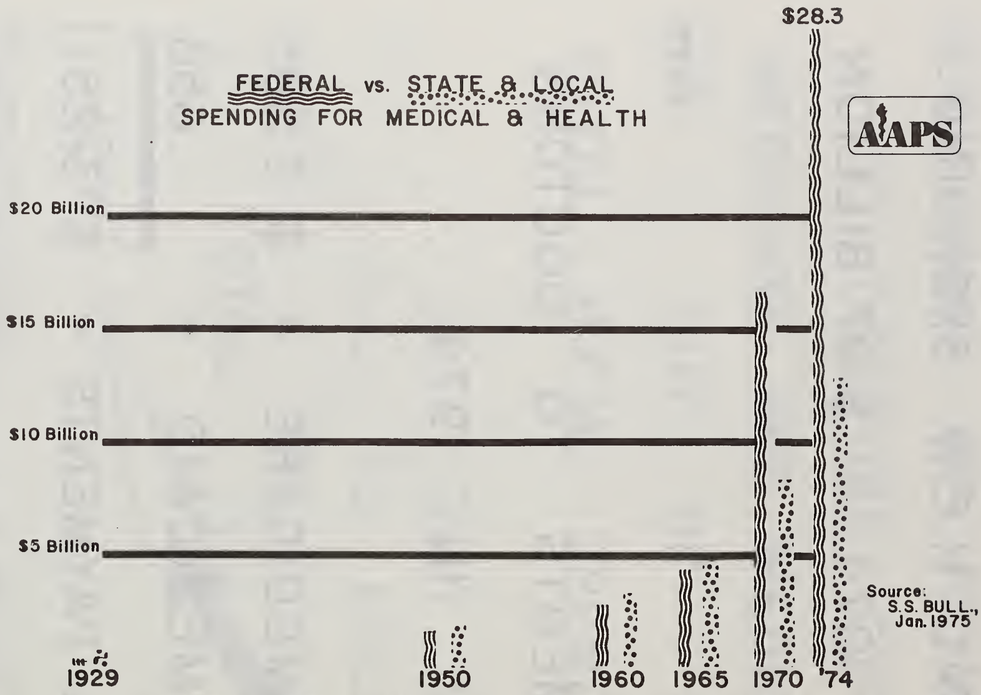
FOR MEDICAID = .656

TOTAL PAYMENTS = $ 3.251

Source: U.S. Budget Special Analysis
Fiscal Year 1975, p. 148-149

"Out of the $97 billion spent by HEW in 1974, only 3.3% -- $3.251 billion -- was in Medicare and Medicaid payments to doctors."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

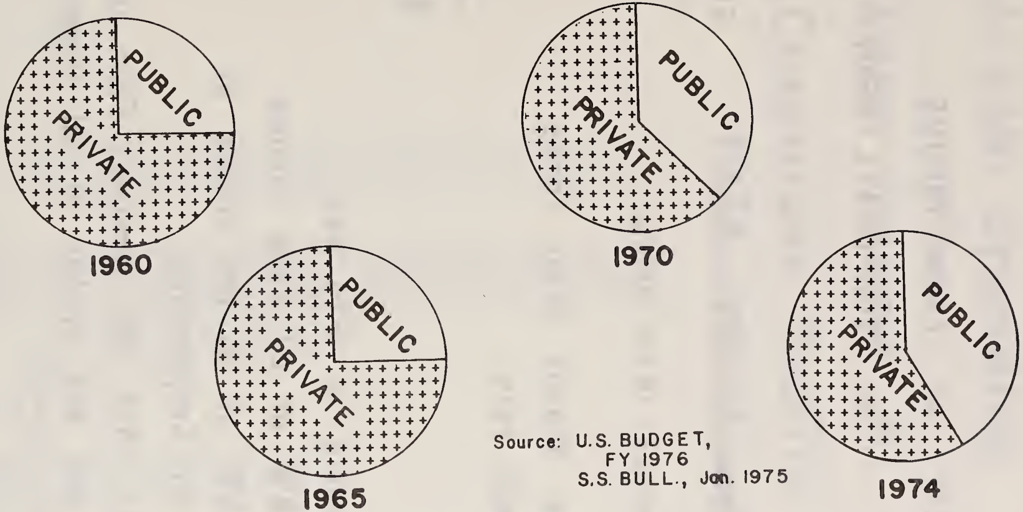


Source:
S.S. BULL.,
Jan. 1975

"This chart compares the medical and health spending by the federal government with that of state and local governments. In 1929, such federal spending was much less than state and local spending, and continued to be less in 1965. But in 1970 the comparison was much different, and in 1974 when HEW spent more than $28 billion, local and state governments spent less than half that amount. This is what happens when centralized government makes puppets out of local and state governments by the device of spend and spend, tax and tax, elect and elect."

-- AAPS testimony on House Ways & Means Committee Subcommittee on Health, 11-5-75

COMPARISON OF PUBLIC AND PRIVATE SPENDING FOR HEALTH



Source: U.S. BUDGET,
FY 1976
S.S. BULL., Jan. 1975

"This chart comparing public and private spending for health is based on data in the January, 1975, Social Security Bulletin which, by its comments appears to take pride in the fact that public spending for health which was about 25% of all spending in 1960, has now risen to become nearly half of all spending for health."

-- AAPS testimony to House Ways & Means Committee Subcommittee on Health, 11-5-75

H.E.W. vs FARM INCOME
vs CORPORATE PROFITS

	Billions
1. H.E.W. Spending 1974 actual	$100.875
2. Farm Income 1974 actual	29.100
3. All Corp. Profits After Taxes 1974 annual rate	69.900
	$99.000

H.E.W. Spending in 1974 was:

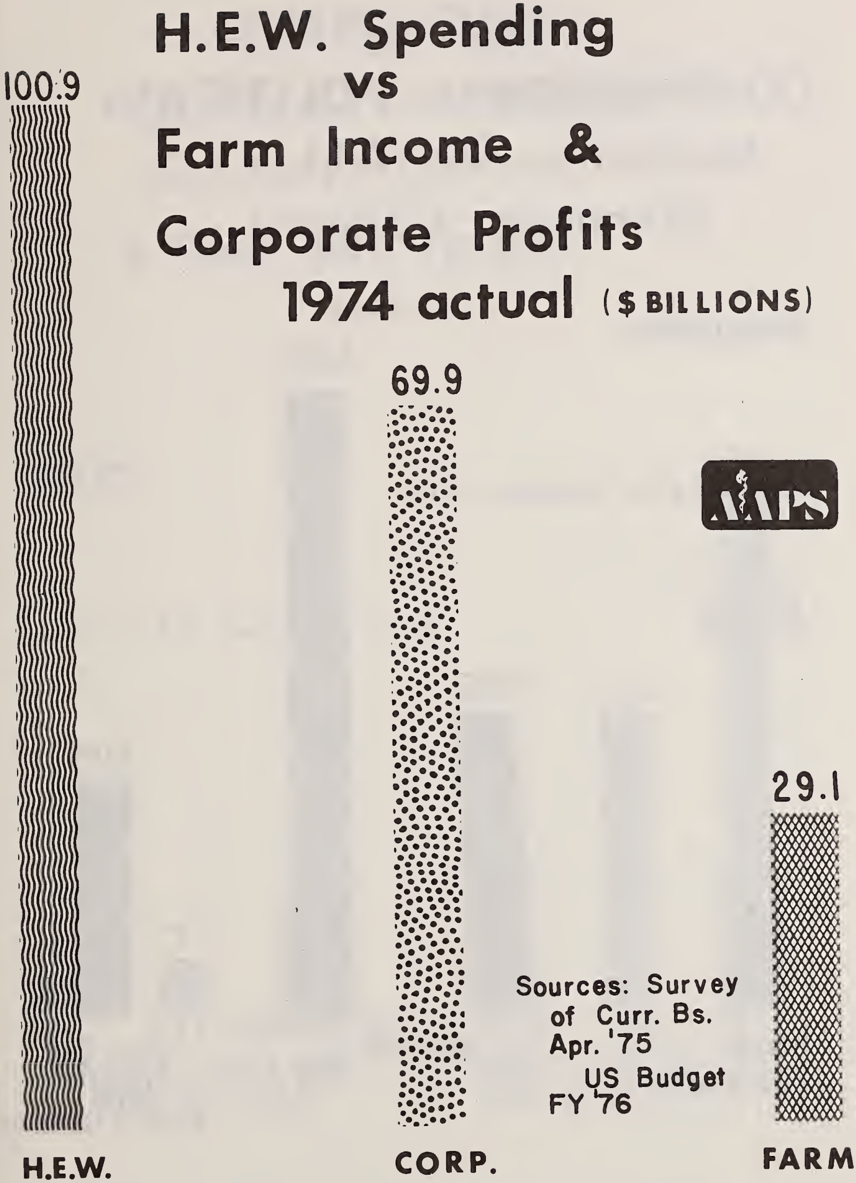
348% of all Farm Income

144% of all Net Profits of all Corporations

more than the combined Farm Income and Net Profits of all Corporations.

Sources:

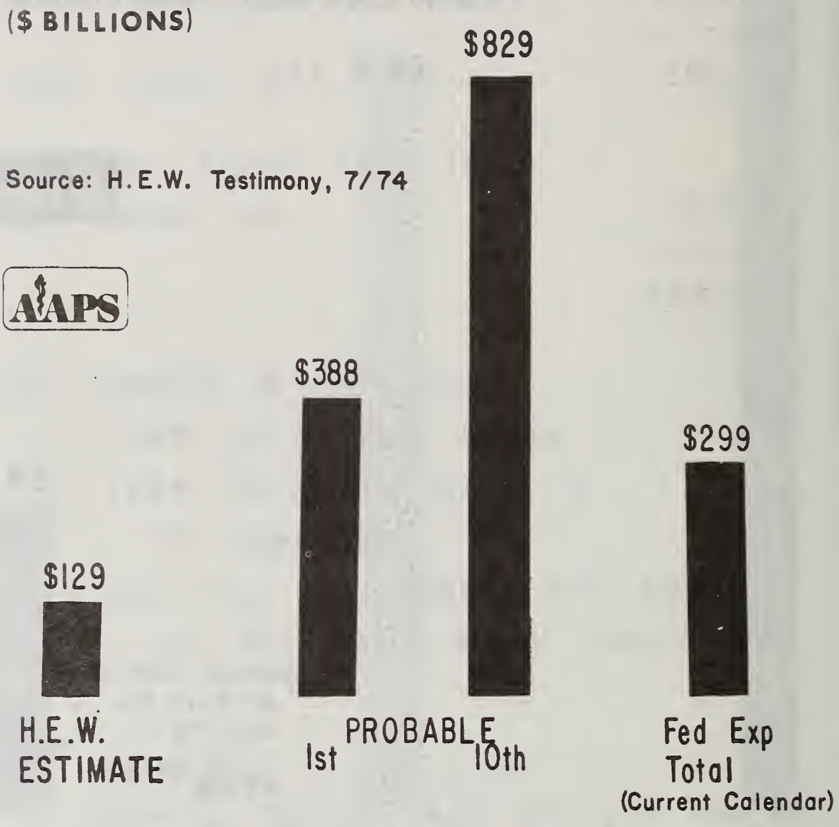
1. U.S. Budget, FY 1976, p.56
2. Survey of Curr. Bs., April 1975, p.15, Table 7
3. ibid. p.16, Table 10



H.E.W. Spending
vs
Farm Income &
Corporate Profits
1974 actual ($ BILLIONS)

Sources: Survey of Curr. Bs. Apr. '75
US Budget FY '76

Cost of COMPULSORY POLITICAL Medicine for ALL (Kennedy–Corman)



Source: H.E.W. Testimony, 7/74

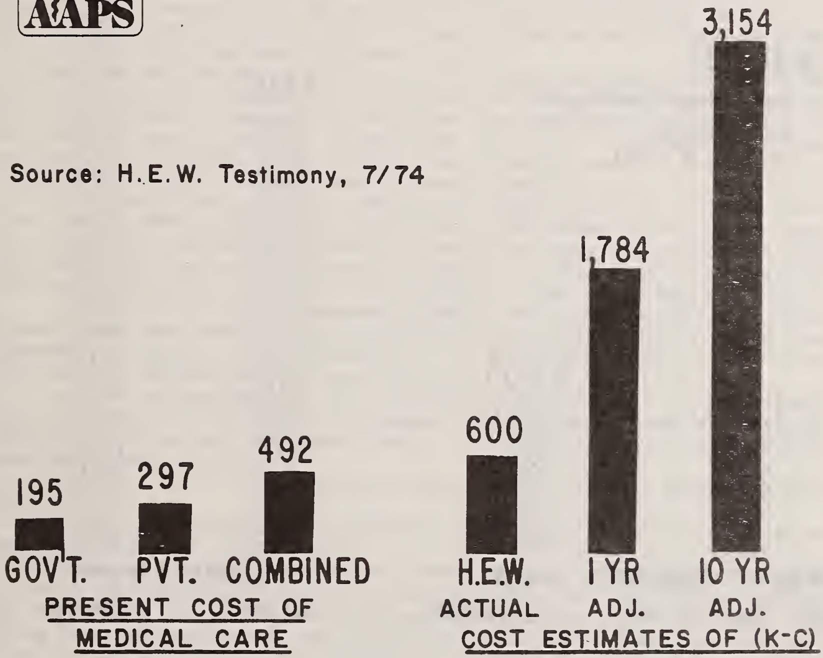
COMPULSORY POLITICAL MEDICINE

(Kennedy – Corman)

$ Cost per Person

(AVERAGE)

AAPS

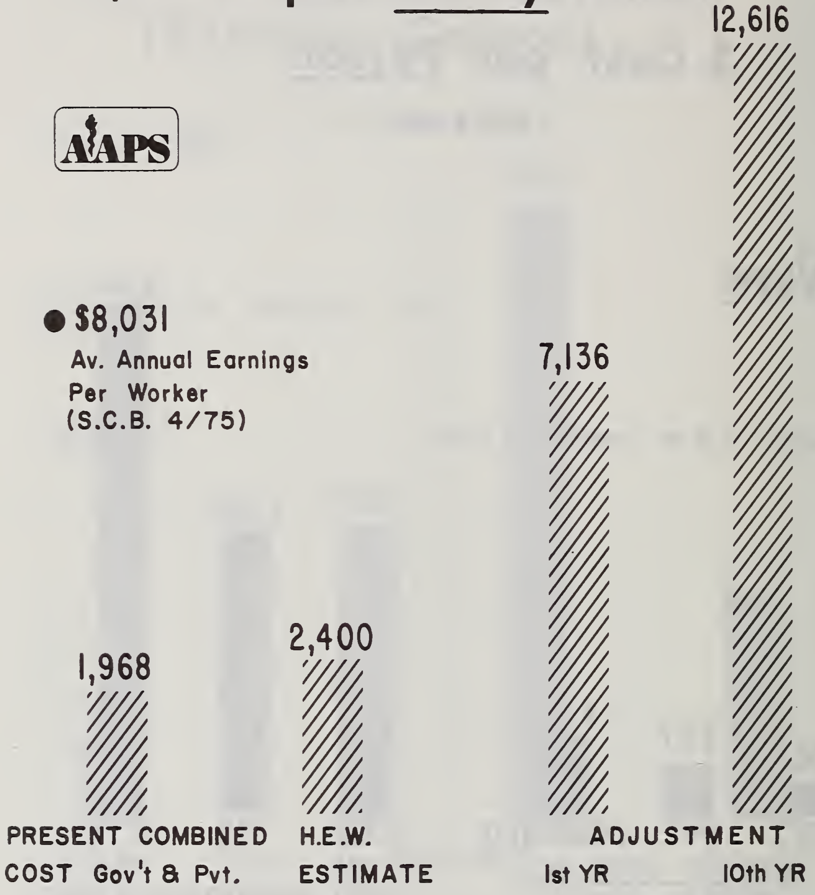


Source: H.E.W. Testimony, 7/74

COMPULSORY POLITICAL MEDICINE

$ Cost per Family of 4

AAPS



Appendix II

Ribicoff, Secretary of H.E.W., testifying before the House Ways and Means Committee in 1961 on H.R. 4222, the King Bill providing for health insurance benefits in hospitals and other facilities.

Health Services for the Aged Under the Social Security Insurance System

ADVANTAGES OF SOCIAL INSURANCE APPROACH

"We have, then, in the social insurance approach these advantages: It is the only way in which people generally can pay during their working years toward meeting their health costs in retirement; it is sound and fiscally responsible; it makes possible provision of basic protection for the aged regardless of where they live; it preserves and increases freedom of choice of doctor and hospital; and it does all this in a way that is consistent with the dignity of the individual." Page 32.

"The cost of the President's proposal: When the administration bill was introduced in February, it provided for full financing of the estimated long-range cost of the program—0.60 percent of taxable payroll . . ." Page 32

"Since the introduction of the bill, the chief actuary of the Social Security Administration, in accordance with his usual procedure, has reevaluated the cost estimates. The estimate of the cost of the hospital services has been fully confirmed in this reevaluation. There is a great deal of information of hospital use under insurance programs, and our assumptions on use of hospitals under the President's proposal seem very safe." Page 32.

"Based on the new assumptions on use of services, the long-range cost of the program is now estimated by the chief actuary at 0.66 percent of payroll rather than 0.60 percent. In accordance with the long-established practice of fully covering the cost of and new benefits that are added to the program, I am recommending that the financing provisions of the proposal be changed so as to keep the program on a sound financial basis." Page 32

". . . Although our most recent estimates indicate that, even with the previously recommended financing provisions, the income earmarked for health insurance benefits would have exceeded the outgo in every year until after 1980, we believe the prudent and advisable course is to make provisions now for the additional income that would be required over the very long run." Page 33

". . . President Kennedy proposes a fiscally responsible method of financing hospital care and certain related health services for the aged in a way that protects the dignity of the individual . . . it would pay hospital bills without interfering with hospital operations." Page 33

" . . . The only satisfactory way of providing the aged with adequate health insurance protection is through a system under which the cost of the health insurance will be paid by people during their working years, together with their employers." Page 37

"Under this bill . . . the doctors are specifically excluded from this bill." Page 181

This is not true, doctors are specifically included. See Ribicoff's own testimony on Pages 35 and 36 in which he says:

"Physicians' services would not be covered except for services in the fields of pathology, radiology, physical medicine, anesthesiology, and services rendered by interns and residents in training, and those services would be covered only when they are provided as part of the hospital's services. Hospitals enter into various kinds of arrangements with doctors specializing in pathology, radiology, physical medicine, and anesthesiology. Some hospitals employ these specialists as salaried staff members; others arrange for these services by contracting with individuals or partnerships. In order to provide payments for these services for beneficiaries wherever provided by the hospitals, the administration proposal would provide payments to a hospital for the services in question whether the specialist is on salary or provides services for the hospital under some other kind of arrangement. Service provided by the patient's private doctor would not be covered, nor would services furnished by mental, tuberculosis, and, in general, Federal hospitals."

"There is absolutely nothing in this bill that is socialization." Page 181.

"This bill has the saving grace—and I am very serious when I say this—that it is conservative. This bill is the most conservative approach, because under this bill, the beneficaries make the contributions, with their employers, to pay for the benefits. They are paying for what they are getting, instead of having the general treasury of the State and the Nation under an open-end proposition make the payment." Page 182.

Mr. Byrnes to Mr. Ribicoff. "Mr. Secretary . . . I enjoyed your lecture on politics and what happens when something is controlled, basically, by the State legislature, when State legislatures are involved. I understand that it is your philosophy that in such cases it immediately goes to pot, but if it is at the Federal level, we can have great confidence that it is going to be administered soundly." Page 188

Ribicoff admits ". . . . I believe it is true that very few, if any, who are absolutely in need or urgent care are turned away from our hospitals because of inability to pay." Page 29

"We know that hospital use by older people goes up when an assumed source of financing is provided on terms that older people find acceptable." Page 29

". . . The Government is already involved in meeting the cost of personal medical care, for the aged as well as for other groups, and on a large scale." Page 29

"Moreover, the social insurance approach affords the best assurance of keeping program costs under control. . . ." Page 31

Mr. Byrnes. " . . . . I just hope that we are not going to be misled and that your facts and figures are more accurate than the case that was presented during the campaign by then Senator Kennedy. I remember a television show where Mr. McNamara, I believe his name is, down in Kentucky was pictured with the candidate for the Presidency and attention was called to his very difficult plight as a result of a broken hip, but no attention was called to the fact, of course, that over four-fifths of the cost had already been paid by Blue Cross and Blue Shield, even though the information that was developed later was that Mr. McNamara had told Senator Kennedy that he was covered by Blue Cross and Blue Shield, but it was suggested by Senator Kennedy that they better not go into that matter in the film. If we are talking about misleading and properly educating the public, I do not think we got off—to a very good start. At least, the administration did not in that particular instance." Page 189

Secretary Ribicoff: "I would say that there is absolutely no way in which this interferes with the doctor-patient relationsip." Page 190

Secretary Ribicoff. "I think there is no nation that has health service comparainterferes with the doctor-patient relationship." Page 193

Secretary Ribicoff. ". . . But I would like to make this clear for the record, that if and when Congress passes the plan for meeting health care costs for the aged under social security, I would not advocate the repeal of Kerr-Mills. The Kerr-Mills approach is a valuable instrument to supplement the social security approach. There could be cases where catastrophic illness would go far beyond the benefits that we advocate in the King bill. And I foresee the "necessity of an instrument like the Kerr-Mills plan coming in and taking up the difference. I would say that the Kerr-Mills plan has a place in our overall health." Page 195

Mr. Curtis. "The point I want to drive home is that I do not believe the Kerr-Mills bill ever was written as a base for health care for the aged or any group in our society. As a mater of fact, my approach is that the basic program, health program, in our society is in the private sector. And that is what really disturbs me about the approach of your Department, coming in here, in my judgment, not having analyzed what our present health care program is in detail, so that you know where its strengths and weakneses are, but coming in and in effect substituting a basic plan in law, which I think is the social security approach for all people, and on a compulsory basis. There is no choice in the proposal which you present here, is there?" Page 195

Secretary Ribicoff. "No, there is not. My predecessor, Secretary Flemming, presented a study of the problem to this committee, even though his conclusions were different from mine, I also gave you a report today. The documents supplementing my testimony are a complete analysis of the problem." Page 196

Secretary Ribicoff. ". . . You can never take care of all of the needs of everybody in any society, no matter what it is." Page 198

Secretary Ribicoff. "I, for one—and I will say this to you publicly—believe there is a limit to how far you can go in social security taxes." Page 199

". . ., it is my opinion that you are coming to a situation where you cannot have much more by way of taxes in a social security program." Page 199

"I do believe that what is needed to round out the social security program is medical care for the aging. A half a percent brings you up pretty close to 10 percent." Page 199

". . . Under this bill there is a direct relationship between the taxes you pay and the benefits you get." Page 201

Cohen is the author of the Kerr-Mills Bill, see statement of Ribicoff on Page 220: "Of course, we have the author right here." Page 220

". . . Everything is relative." Page 221 (There are no absolute truths.)

Mr. Ullman. "In other words, you would be willing to delegate this right to accredited hospitals and would not assume any dictatorial power over any individual hospital?" Page 224

Secretary Ribicoff. "Not only would I be willing; I would welcome this cooperation. This is a big job. I would give the greatest respect, as I do now, to the joint commission on hospital accreditation. I think they are doing a fine job in America to raise the standards of our hospitals, and I would not look behind their accreditation." Page 224

"I do not see any difference between this and Blue Cross." Page 224 (Can't see the difference between public and private.)

"I would say whether the person needs hospital care will be determined only by one person—nobody in Washington—by the man's own doctor." Page 235

"In other words, the only one who is the judge of whether someone goes into a hospital is the man's own physician." Page 235

Mr. Betts. "In other words, the doctor says that the patient has to go to the hospital, that is it?" Page 235

Mr. Ribicoff. "That is right, he goes in." Page 235

Mr. Ribicoff. "... We do not want to set up a boondoggle." Page 236

Mr. Betts. "There is no policing the system?" Page 236

Secretary Ribicoff. "We would take the word of the hospital utilization committee; yes, sir. We do believe that the hospital is honorable and the doctors that will be on the staff will make sure that this is not abused." Page 236

Mr. Betts. "I am not questioning the hospital's good faith, but there are differences of opinion. That is where the problem comes. There is a difference of opinion as to whether or not a hospital should be accredited." Page 236

Secretary Ribicoff. "Somebody has to judge." Page 236

Mr. Alger. ". . . It is quite obvious that all of the aged that need the help will not be covered by this bill." Page 237

Secretary Ribicoff. "Yes. There will be some people that will not be covered by this bill." Page 237

Secretary Ribicoff. "Because we are going to cover that part of the population who, as statistics show overwhelmingly, do not have the income or the means to take care of their serious catastrophic illness, and who cannot take out private insurance. The largest segment of the population under 65, a much larger percentage, have insurance of one sort or another and have means which enable them to pay the cost of illness or are part of a plan in their employment which gives them coverage. So we are taking care of the people who are not otherwise covered." Page 238

Mr. Alger. "I happen to feel that actuarially, with all respect to Mr. Myers, this program is not sound and if I am right, and I only suggest this as a possibility, then you are tacking on the medical care of our people as well as their retirement future incomes and livelihoods to a program that actually could crash of its own weight because it is actuarially unsound, . . ." Page 239

APPENDIX III

Medicare-medicaid cost in 1976 fiscal year

MEDICARE		
Hospitalization:		
Payments	(billions)	$9,683
Administrative expense	(millions)	330
Subtotal	(billions)	10,013
Supplemental medical insurance:		
Payments	(billions)	4,126
Administrative expense	(millions)	515
Subtotal	(billions)	4,641
Subtotal medicare	(billions)	14,654
MEDICAID		
Federal share:		
Payments	(billions)	$6,829
Administrative expense	(millions)	327
Subtotal	(billions)	7,156
Subtotal Federal medicare and medicaid	(billions)	21,810
State share:		
Payments	(billions)	6,696
Administrative expense	(millions)	247
Subtotal	(billions)	6,943
Subtotal medicaid	(billions)	14,099
Grand total medicare and medicaid (P.L. 89–97)	(billions)	28,753

Source: Special Analyses, Budget of the United States Government, Fiscal Year, 1976, pp. 183–184.

Mr. ROSTENKOWSKI. Thank you, Mr. Woolley.

Mr. Duncan will inquire.

Mr. DUNCAN. Dr. Campbell, do you know of any problems existing at the present time where people do not receive proper medical care?

Dr. CAMPBELL. Would you restate that question, please?

Mr. DUNCAN. Do you know of any problems at the present time where any segment of the population is not receiving adequate and proper medical care?

Dr. CAMPBELL. No, sir. I have been in the practice of medicine for 21 years, and we have rendered medical care to folks a long time before medicare and medicaid or Kerr-Mills or King-Anderson were ever dreamed up. We rendered care to folks in our offices, in the emergency room, and in the hospital, when they needed it.

We don't need these of so-called national health insurance bills in order to get people cared for. It is our God-given right to render charity to folks who need medical care.

Mr. DUNCAN. What percentage of your work would you say is charity?

Dr. CAMPBELL. I really don't keep that kind of figures in my mind.

Mr. DUNCAN. I am sure you could give us an estimate.

Dr. CAMPBELL. It could be 10–15 percent.

Mr. DUNCAN. We have had testimony in the past when segments of the population, say with incomes of $5,000 to $10,000, they are not eligible for public welfare and indigent care, who do not have funds for their medical attention. How would you take care of those people?

Dr. CAMPBELL. It is quite simple, sir. Before medicaid ever came along, I handled a lot of little old ladies and little old men in my practice who came to me, and they paid what they could, or they didn't pay, or their children paid. I happen to believe that the first responsibility lies with the individual, second with the family, the children—the best kind of insurance you can buy is children—with other relatives, nieces, nephews, and finally with neighbors, friends, the churches, the Salvation Army, the Red Cross, and so forth.

We have in our community the Gerrity Charity, the Grain Foundation, the Family Service Corp., and any number of other charitable organizations that are just delighted to help with these kinds of problems.

The city and the county governments and finally the State governments should be responsible—but never should this problem extend beyond State governments.

Mr. DUNCAN. How many members do you have in your Association of American Physicians and Surgeons?

Dr. CAMPBELL. Well, sir, we don't try to play the numbers game.

Mr. DUNCAN. Well, I just wonder how many you represented.

Dr. CAMPBELL. I would just say that we do have thousands of members, that we have members in every State in the United States, that we have members well distributed throughout congressional districts, and that these members do talk to patients daily and they will be talking to these folks about proposed compulsory politicalized medical care—in hopes of getting these folks better informed before the coming elections.

Mr. DUNCAN. But you don't know how many in numbers you actually have?

Dr. CAMPBELL. I couldn't tell you the exact numbers. I am not privy to that information.

Mr. DUNCAN. Thank you very much. We thank you very much for coming.

Mr. ROSTENKOWSKI. Mr. Corman will inquire.

Mr. CORMAN. Thank you, Mr. Chairman. You have members in California; is that true?

Dr. CAMPBELL. Yes.

Mr. CORMAN. We have a problem in California now with medical malpractice insurance. Do you think the Federal Government should concern itself with the problem of malpractice and malpractice insurance?

Dr. CAMPBELL. No, sir. I do not. I think that, again, is a problem for the individual, for the States, and it should not extend beyond that in any way, shape, or form.

Mr. CORMAN. At either the State or Federal level should there be a law prohibiting doctors from conspiring to strike?

Dr. CAMPBELL. My personal feeling is that I would not condone a strike. But on the other hand, I don't think we need all these laws. I think we have too many laws now.

Doctors have principles and ethics we abide by. The Association of American Physicians and Surgeons never has advocated a strike, and we never will. I can't speak for doctors' unions. But I don't think we ought to have a law such as you suggest. I think we have too many laws now.

Mr. ROSTENKOWSKI. Mrs. Keys will inquire.

Mrs. KEYS. Thank you, Mr. Chairman. I have just one question.

I would very much like to have your response to what to me is a very basic question. Do you think that in 1975, in the United States of America, with the kind of resources it has, everyone ought to have access to quality health personnel for their problems at a cost they can afford?

Dr. CAMPBELL. I think everyone does have access to quality health care at a cost they can afford. As I just pointed out, if they can't afford any at all, it is still available to them.

Mrs. KEYS. You do believe that they should?

Dr. CAMPBELL. They do have. It is not a matter of whether they should or not. They do have. That settles the issue. It is already available and there is no problem.

Mrs. KEYS. Well, I could bring you instances and statistics and cases unlimited where they don't. But I wanted the answer to your belief, if this was an essential right of the people in this country today.

Dr. CAMPBELL. Let me tell you something about rights.

Mrs. KEYS. I think you have and I believe my time has expired. Thank you.

Dr. CAMPBELL. Rights are God-given. The right to life, liberty and property, those are God-given rights.

Mrs. KEYS. I agree.

Dr. CAMPBELL. They are not given by people, Congressmen, bureaucrats, politicians.

Mrs. KEYS. I agree with that, sir, and often the right to life does hinge upon the right to medical care being available that one can afford.

Thank you very much.

Dr. CAMPBELL. Christ said the poor will always be with you.

Mr. ROSTENKOWSKI. Mr. Stark?

Mr. STARK. I am speechless, Mr. Chairman. Thank you.

Mr. ROSTENKOWSKI. Thank you, gentlemen.

Mr. WOOLLEY. Thank you.

Mr. ROSTENKOWSKI. Our next witness is Dr. Francis Davis.

Welcome to the committee, Doctor. If you would identify yourself and your association you may proceed.

STATEMENT OF FRANCIS A. DAVIS, M.D., PRESIDENT, CONGRESS OF COUNTY MEDICAL SOCIETIES

Dr. DAVIS. Thank you.

Mr. Chairman, and members of the subcommittee, my name is Francis A. Davis. I am a medical doctor in private practice in Shawnee, Okla., and I appear before you today as president of the Congress of County Medical Societies, a national organization representing the private practice physicians of this Nation.

Thank you for the opportunity to testify on the important subject of national health insurance. It is crucially important, because the legislation you are considering has the potential for destroying the finest system of medical care in the world while at the same time drastically increasing the tax burden of the American people.

The Congress of County Medical Societies totally opposes all further intrusions by the Federal Government into the private practice of medicine. We are therefore against national health insurance.

WHY WE OPPOSE GOVERNMENTAL MEDICINE

There are many reasons why this subcommittee should reject national health insurance in all its guises.

1. It will lower the quality of the medical care our patients receive. Were any of you enlisted men in the Armed Forces? Do you remember the medical care you received? How impersonal and bureaucratic it was? Is that what you want to inflict on the American people? Do any of you doubt that Medicaid, the VA, and the New York City municipal hospitals—to name only three other examples—deliver poorer quality of medical care than private doctors and private hospitals? HEW and the Social Security Administration are no more capable of providing high-quality medical care than Amtrak is of running an efficient railroad.

2. It will increase the cost of medical care by at least 150 percent, if past governmental medical programs are any guide. HEW, in typically understated fashion, says a comprehensive national health insurance plan will cost $113 billion the first year. I think we only have to remember that Medicare now costs 300 percent more than HEW said it would.

Last summer, the Washington Post, heretofore an ardent supporter of Corman-Kennedy, said in an editorial that national health insurance "involves a sufficiently large number of billions of dollars to induce extreme caution."

And the Social Security Administration's own preliminary study of the costs of national health insurance, the Vogel-Blair report, says that full-scale involvement of the Federal Government in medicine will be disastrous for the economy.

3. It will bring about the rationing of medical care for the patients of this Nation. When a scarce resource is offered to the public at an artificially low price—or worse, at zero price—demand skyrockets. Rationing is the only answer short of bankrupting the country. But this is not much comfort to the patient denied needed treatment.

Even the resources of the U.S. Government are not unlimited. Consider for a moment what would happen if you made airplane flights out of National and Dulles free, with the CAB picking up the tab. What would that do to the Federal budget? What would happen to the people who really needed to fly? It would take them months to get on a plane, and service would deteriorate before the rush of passengers.

Writing in the Scientific American, Dr. Sidney Garfield, founder of the Kaiser-Permanente HMO, and no friend of fee-for-service medical care, said—

> Elimination of the fee had always been a must in our thinking, since it is barrier to early entry into sick care * * * Only after years of costly experience

did we discover that the elimination of the fee is practically as much of a barrier to early sick care as the fee itself. The reason is that when we removed the fee, we remove the regulator of flow into the system and put nothing in its place. The result is an uncontrolled flood of well, worried-well, early-sick and sick people into our point of entry—the doctor's appointment—on a first-come, first-served basis that has little relation to priority of need. The impact of this demand overloads the system and, since the well and worried-well people are a considerable proportion of our entry mix, the usurping of available doctors' time by healthy people actually interferes with the care of the sick.

This is what will happen under national health insurance.

4. It will substitute bureaucratic dogma for the judgment of physicians. If one of you gentlemen needs a hernia operation—or ladies—do you want its necessity decided by your doctor and you, or by an anonymous bureaucrat in HEW?

We have seen a prelude of this in the way the Food and Drug Administration acts. The judgment of practicing physicians with decades of clinical experience means nothing when it comes to deciding how drugs should be used or which ones should stay on the market. Instead the FDA substitutes its own judgment and that of its pet academic experts as to efficacy. The doctors who actually care for sick people are themselves treated like children.

SOME PERSONAL EXPERIENCE

Now some personal experiences. Although the example of foreign countries has shown us that government is incapable of providing reasonable priced, high-quality medical care, our present Federal programs prove this also.

In Shawnee, where I am a general practitioner, we have an Indian Health Service hospital. The Government doctors are on duty 9 to 4, 5 days a week. If an Indian patient gets sick at night or on the weekend, he is out of luck. Here is the essence of bureaucratic medicine. Of course, the private physicians of Shawnee care for Indian patients when the Government will not, but what will happen when there are no more private doctors?

I treat any patient, whether he can pay or not. But I do not take Medicare or Medicaid assignments. I refuse to waste my time—time I spend on my patients—wrestling with bureaucrats.

One winter I had a patient with acute epididymitis, a serious and painful illness. He should have been in the hospital but he refused to be admitted, preferring to be at home with his family. So I treated him from my office and I was able to help him get well. But the nature of the illness required my seeing him often, including on Christmas and New Year's Day. My total bill, including laboratory work, was $67. Medicare refused to reimburse this patient. The clerk explained to him that the claim was erroneous, because doctors do not see patients on Christmas and New Year's.

Gentlemen, let me give you a brief history of my experiences with medical legislation. The first medical program was Kerr-Mills, sponsored by my late friend Senator Robert S. Kerr of Oklahoma. At that time, Senator Kerr promised that if doctors would support his program, there would be no further extension of Federal control over medicine. The Senator kept his word and worked hard to prevent its extension. In the summer of 1961, I was Senator Kerr's guest here in Washington when he was able to get a proposed medicare bill tabled in the Senate. The bureaucrats worked hard, too; they did all they could to make Kerr-Mills a failure.

We all know what happened in the ensuing years. A young President was murdered, Senator Kerr had died, and the way was cleared for medicare and medicaid. Organized medicine was again proposed, "Work with us to make these programs successful, and you will never have national health insurance." The officials of organized medicine did cooperate with HEW, and together they drew up many recommendations to guarantee quality medical care. But in spite of HEW's solemn promises, the recommendations were ignored.

I could tell you many other stories to illustrate how patients and doctors were sold an expensive program of poor quality governmental medicine.

ENGLAND

Last summer, I went to England with the other members of the Congress of County Medical Societies and a group of Congressmen, including some on this subcommittee. I visited hospitals and doctors' offices. I talked to patients and physicians. I learned that in that unhappy country rationing of medical care means 700,000 patients on waiting lists for surgery—by the British Government's own count, general practitioners so mobbed that they can only devote an average of 4 minutes to each patient, the complete absence of the comprehensive physical examination, and women getting pap smears only every 5 years.

Most terrible of all, I saw the destruction of the doctor-patient relationship so essential to proper healing.

Gentlemen, medicine is more an art than a science, and a doctor must be free to treat each patient as unique, as indeed he is, and not as a norm on some governmental set of standards. Some aspects of scientific medicine may survive governmental control, although Solzhenitsyn says no, but the art dies, and with it, most of what is effective and all of what is humane in medical care.

Let me read you a message I recently received for our good friend, Dr. Richard J. Lavelle, a London surgeon, which I think very excellently represents the point.

> I am a hospital consultant. My National Health Service appointment is at St. Bartholomew's Hospital, which is the oldest teaching hospital in Great Britain. I have what is called a maximum part-time contract which, by surrendering two-elevenths of my Health Service salary, entitles me to do private practice. I spend approximately thirty percent of my working time in private practice and the remainder in the National Health Service hospitals. In this latter time not only do I have my clinical responsibilities but also I am responsible for teaching my specialty to medical students, postgraduate students, nurses, and general practitioners.
>
> During my years as a medical student I was in favor of a National Health Service. The emotional appeal of a service free at the point of receipt by the ill patient was to me beyond question. That the availability of medical treatment should be related to ability to pay was anathema to me. In a society whose facilities are infinite I would hold this view, but if there is any limit to the resources of a given society, then I have changed my views radically as to the desirability of involvement in medical care by the government.
>
> Even the most casual observer working both in the private and government hospitals could not fail to notice truly amazing differences in the level of morale of those employed in the two systems. This extends through medical, nursing, and technical staffs. In my government hospitals the level of morale has fallen to an alarming level and this naturally reflects adversely on the standard of

service offered to the patients. For many months past three out of my department's weekly quota of nine operating lists are cancelled—at present this is due to a chronic shortage of anesthetists. And this state of affairs, I emphasize, has arisen in one of our most prestigous hospitals. Standards are now so low in the National Health Service that there is no prospect of a non-urgent patient going on my waiting list today (Fall 1975) having his operation before Spring 1977 at the earliest—if the situation continues to deteriorate there would be no chance of a new non-urgent patient ever reaching the top of the waiting list. I have therefore reached the decision of having large numbers of waiting patients, large numbers of empty beds, and desperately restricted facilities to deal with the problem.

The contrast in the private sector is enormous. There the beds are full most of the time and every possible assistance in the provision of personal and technical facilities is given. The staff stay on duty willingly until the work is done. However in the government system we have been plagued by strikes, working to rules, go slows, clock watching, and so on.

It has been a matter of great disquiet to me to watch the progressive loss of morale in the National Health Service and the consequent lowering of standards. Fortunately while our private sector continues to flourish, comparisons can still be made. Whereas in this country the individual has to make no positive decision for himself as to whether to avail himself of the facilites provided, the flood of trivia and the demands made on our limited resources makes for a profound lowering of the standard of care available to those in real need.

One of my main criticisms of the National Health Service system is its inability to concentrate its limited resources where they are really needed. A 'free' service at the point of receipt inevitably results in the jam being spread too thinly and not concentrated at the point of maximum need. In fact the resources are diverted to the point of maximum demand, which is often very different from the point of maximum need.

What has been the solution proposed to these problems?

It only requires a casual glance at the current British press to show that our National Health difficulties are being tackled purely with political solution. For example, facilities in National Health Service hospitals for the treatment of fee-paying patients will be abolished—I would point out that these patients contribute fully to the costs of running the National Health Service but they committed the unforgivable sin of consulting a specialist of their own choice privately. In the same Ministerial statement we are told that foreigners (who are inevitably private patients) are to continue to be allowed treatment in National Health Service hospitals because of the high international standing of British medicine. These and like decisions are going to produce a two-tier system in this country to the advantage of no one and the positive disadvantage of the patient. We are told with one breath that facilities and finances are to be cut back with a target figure of ten percent reduction and in the next breath 30-40 million pounds per annum is going to be thrown away by banning private patients in State hospitals. This is how I see a purely party political decision adversely affecting the welfare of the patients.

A positive plethora of new administrations and administrative grades have sprung up resulting of course in delays in decisionmaking and more and more committees being needed to make the most trivial decision. Before the introduction of the National Health Service, one of the hospitals in which I have had one accountant and a secretary who did all the wages and salaries of the hospital. That same hospital now has fourteen employees in the same department without any increase in the number of patients in the hospital. The administration of a hospital is an irrelevance if there are no patients.

I conclude by saying that in my opinion for the following principal reasons the theoretical attractions of a government health service are outweighed by the practical disasters which incur:

1. Inability to concentrate resources where they are really needed;
2. Massive administrative costs and delay in decisionmaking;
3. Lowering of morale of those involved in the treatment of patients;
4. A bad deal for the patient.

REGULATIONS

For the past 13 years, the doctors of this Nation have been tied in a bundle of regulations that have brought many patients under bureaucratic control. The result is less productive physicians. We have to spend too much time serving on Government-mandated committees, answering Government clerk's questions about, why we did this or that, filling out mounds of useless questionnaires, none of which ever helped a patient get well.

Gentlemen, Government intrusion into medical care has caused enough problems already. Don't exacerbate the situation with national health insurance. In fact, the Congress of County Medical Societies hopes that Congress will work on ways to lessen the scope of Government control over patients and doctors, not increase it.

Right now, the Food and Drug Administration is trying to stop practicing physicians from learning any clinical information or research data about drugs that is not spoon-fed us by the FDA. This unconstitutional censorship of scientific information should also be looked into by Congress.

RECOMMENDATIONS

Thank you for your time. It has been an honor to address the Health Subcommittee.

I sincerely hope that you will not make patient care any more difficult than it is now, by recommending national health insurance to the full committee and the House.

Fighting disease is a full-time job. In America, we are blessed with over 240,000 practicing physicians and surgeons, the vast majority of whom are highly skilled and dedicated to their patients. They have given the American people the best medical care, charging those who could afford to pay, and—in an ancient tradition—not charging those who could not.

Their work should be encouraged, not made more difficult by increased Federal interference.

Leave medical decisions to patients and doctors. Keep HEW out of it.

Thank you very much.

Mr. Rostenkowski. Thank you, Dr. Davis.

Mr. Crane will inquire.

Mr. Crane. Thank you, Mr. Chairman.

I welcome the opportunity to make some inquiries of a good friend and very able and talented physician, Dr. Francis Davis.

Dr. Davis, rather than going to your testimony, I would like to go over some of the remarks of Mr. Woodcock's testimony from your perspective. Mr. Woodcock in his statement talks about people deliberately seeking to misinterpret aspects of our health care delivery system. He charges "distortion from Madison Avenue hucksters employed by the vested interests." I do not think you would classify yourself as a "Madison Avenue huckster for vested interests," so presumably you could give us some more objective answers to some of the indictments that Mr. Woodcock makes.

First of all, he talks about the problem of poor distribution of services, shortages of family physicians, and duplicative, disorganized, and excessively high cost of services. He suggests all of these have intensified most recently in the health care field.

Could you comment on that statement?

Dr. Davis. Well, I would like to say as far as distribution of physicians, with the present means of transportation, a survey ran a couple years ago by Hillsdale College in Hillsdale, Mich., for us, led us to believe that no one is more than 25 minutes from adequate medical care in this Nation.

Now, I am sure that there are areas down inside of New York City and such that do just not have doctors, and that is because we do not have many other businesses there, either. Just because it is not the proper thing to have a business, but within 25 minutes there are doctors available, and that is about as good a distribution I think that you can provide. If you only think back some 50 years ago, a man living 2 or 3 miles from Shawnee, it took him 25 to 30 minutes on a fast-running horse to get to a doctor or the doctor to get out to his home.

So I do not believe the distribution is in fact a big problem. We have also found that when we explored this problem in England, that their distribution is much more critical than our distribution problem because doctors have just decided it was not worth it and have left.

Many areas in England, instead of being like our county, 1 doctor per 600, there may be 1 doctor per 3,000 or 4,000 people. So, I do not believe our distribution is a problem.

Mr. Crane. There is another charge he makes about our allegedly deteriorating health care service. He suggests that American families played Russian roulette with the lives and health of their children. He says this past year was one in which 5.3 million of our 13.2 million preschool children were unprotected against the crippling infectious diseases: Polio, measles, rubella, diphtheria, whooping cough, and tetanus.

I know there has been a rather active campaign in the Washington area and in Chicago as well to alert parents to the fact that they cannot take for granted the health of their children, and because these diseases have virtually disappeared, they have failed to inoculate their children when that service is available.

How would you explain this statistic that Mr. Woodcock quotes?

Dr. Davis. Well, the ability to get and to deliver the preventative medicine is here. Now, whether or not we are able to train people to go and get it, that is another problem. That has nothing to do with medical care. That has something to do with education.

That is another long ball game. But actually there is no question that there are plenty of ways to get preventative medicine. No one in this county turns anyone down for preventive medical injections. It is a matter of educating the parents to go get it for their children. You certainly will not do any better with a national health insurance. In fact, I think you will have less opportunity to get preventive medicine because these people will not take their children to places where they have to stand in line for an hour or two. They will not even come where it takes just 5 minutes now to get it. In a national health insurance program, there will be long lines, and this would be preventing good medical care more than actually helping people to get good medical care. I do not think it is a matter of being unable to deliver the care; it is a matter of people not wanting it or unwilling to go get it.

Mr. Crane. Mr. Woodcock has another startling figure in here, he says this has been a year in which one-third of all pregnant women who delivered in public hospitals had no prenatal care and consequently ran high and unnecessary risks to themselves and their babies.

Dr. Davis. These statistics are not totally accurate. I am not saying that this did not happen because it probably did. If this did occur, it was because the women did not seek this care. I deliver babies, and I arrive at the hospital some nights at 3 in the morning and deliver an Indian lady who is supposed to be under the care of the free Indian hospital, and she has never been seen or been taken care of.

So there again it is education. It is not a lack of facilities as such, and I am sure that none of us want to arrive at 3 a.m. in the hospital and deliver women, when nothing is known about them. We have other facilities available in Shawnee but we cannot make these people use these facilities.

Mr. Crane. Dr. Davis, unfortunately my time has expired and I appreciate your testimony this morning.

Mr. Rostenkowski. Mr. Corman will inquire.

Mr. Corman. Thank you, Mr. Chairman. Doctor, is Los Angeles County one of your constituent groups?

Dr. Davis. Yes, sir.

Mr. Corman. We have a serious problem in California concerning medical malpractice insurance. Do you think the Federal Government should do anything in that respect?

Dr. Davis. I have no answer to malpractice insurance. I do not think anyone does at this time. I certainly do not think it is a Federal problem. I think it must be acted on at the State level. I think we have many other problems in insurance, very similar problems. I do not think it could be answered by Federal laws.

Mr. Corman. Thank you.

Mr. Rostenkowski. Mr. Burleson.

Mr. Burleson. Thank you, Mr. Chairman.

Doctor, I assume that, from your testimony, there is no national health insurance legislation that you think would be proper?

Dr. Davis. No, sir. Medical care is too personal. It must be handled in the private area and it can be handled in the private area. I think all of us believe these problems, including catastrophic insurance, can be handled privately. Catastrophic insurance can be sold very cheap and I do not think this is the place for the Federal Government. We know it is not. I think statistics prove us out on this fact very definitely.

Mr. Burleson. Thank you.

Mr. Rostenkowski. Mrs. Keys will inquire.

Mrs. Keys. Thank you, Mr. Chairman.

I would like to ask one question of you. I was a little concerned with your statement that the usurping of health care personnel and facilities time by the healthy interfered with the availability for the sick.

We have heard a great deal of testimony in this committee and most of it has been very cognizant of the fact that preventive care is very much needed in order to lessen the demand on acute care and that really our system now does not encourage or make it possible for people to have preventive care unless they happen to be very wealthy and able to afford it.

Dr. Davis. Well, I practice in a town that is not wealthy and we have plenty of preventive care. I am sure that is not true there and I am sure it is not true in Kansas and many, many areas.

Mrs. Keys. Do you believe it is important that we have a system that makes preventive care accessible to people?

Dr. Davis. Well, it is already accessible but you cannot educate people to avail themselves of this. This is it. We have pap smears, ladies can go get them after 6 or 3 months if necessary. And many well-educated people do not show up until 5 or 10 years and it is too late. But that is education.

Mrs. Keys. You are talking to me about your situation. I understand that. I wonder if you did agree that this was a part of providing health care for people that they had the availability of preventive health care and it was an important factor in not only lessening the total cost of the health care burden in this country but in making people able to live happy, healthy, longer lives?

Dr. Davis. I think this is available in most areas and I am sure it is.

Our problem is simply that people will not obtain it when it is available. I do not believe this is the place for the Federal Government to enter.

Mrs. Keys. I believe that you have said you do believe that it is important that it be there, though.

Dr. Davis. It is there in the private practice there today. Come in my office and that is what I do about 50 percent of the time, preventive medicine.

Mrs. Keys. Thank you, sir. You have answered my question.

Mr. Rostenkowski. Doctor, does your organization do anything to encourage mothers to have their children inoculated from polio, diptheria or anything like that? Does your organization encourage this, do they have any program to encourage mothers to have their children inoculated?

Dr. Davis. Not per se. This is not part of our work. Each doctor in the organization certainly encourages it.

Mr. Rostenkowski. Are there further questions?

Thank you, Doctor.

Dr. Davis. Thank you.

Mr. Rostenkowski. Our next witness is Mr. Leonard Woodcock.

Welcome to the committee, Mr. Woodcock. If you would identify yourself and the organization you represent and proceed with your testimony.

STATEMENT OF LEONARD WOODCOCK ON BEHALF OF THE HEALTH SECURITY ACTION COUNCIL AND THE INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UNITED AUTO WORKERS, ACCOMPANIED BY DR. I. S. FALK, PROFESSOR-EMERITUS OF PUBLIC HEALTH, YALE UNIVERSITY, CHAIRMAN, TECHNICAL COMMITTEE, COMMITTEE FOR NATIONAL HEALTH INSURANCE; MELVIN A. GLASSER, MEMBER, TECHNICAL COMMITTEE, AND DIRECTOR, UAW DEPARTMENT OF SOCIAL SECURITY; AND MAX W. FINE, EXECUTIVE SECRETARY, HEALTH SECURITY ACTION COUNCIL

Mr. Woodcock. Thank you very much. I assume the statement I provided will appear in the record.

Mr. Rostenkowski. In its entirety.

Mr. Woodcock. Mr. Chairman, and members of the Health Subcommitteee, my name is Leonard Woodcock and I appear before you today on behalf of the 5 million members of the United Auto Workers families, and the 80 national organizations which comprise the Health Security Action Council. With me is Dr. I. S. Falk, professor emeritus of public health, Yale University, chairman of the technical committee of the committee for national health insurance; Melvin Glasser, member of the technical committee and director of our department of social security. To my extreme left, Max Fine, executive secretary of the health security action council.

Mr. Chairman, we are here today in support of the Health Security Act, H.R. 21, and to comment on other health care proposals under consideration. We have already testified extensively before the Ways and Means Committee and two committees of the U.S. Senate about why we support the Health Security Act. We are grateful to the more than 100 members of this body who are cosponsoring this important and inevitable legislation. We stand for health security. Our reasons are on the record.

We have testified as to what health security is and what it is not. We have shown how it will produce urgently needed changes in the health care delivery system. We have discussed its quality control features, the needs for which are growing even faster than malpractice insurance premium increases. We have provided data about its costs, cost controls, and cost-saving features, and we will continue to update these data and not be intimidated by those who are deliberately misinterpreting the costs of health security.

Your committee has not yet acted on this urgent problem, but we hope that the new round of hearings which you are now undertaking will finally produce a health security program for all Americans.

As a result of the administration's totally incomprehensibe position on this issue, not much attention has been paid to the health care problems of the American people in the past year. However, it has been a year in which the health care crisis has grown worse.

The problems of poor distribution of services, shortages of family physicians, and duplicated, disorganized and excessively high cost of services have all intensified.

It has been a year in which millions of American families played Russian roulette with the lives and health of their children—a year in which 5.3 million of our 13.2 million preschool children were unprotected against the killing and crippling infectious diseases: polio, measles, rubella, diphtheria, whooping cough, and tetanus.

It has been a year in which one-third of all pregnant women who delivered in public hospitals had no prenatal care and consequently ran high and unnecessary risks to themselves and their babies.

It has been a year in which millions of America's laid-off workers joined both the lines at the unemployment office and the swollen ranks of 40 million Americans who face disaster in the event of even a short acute illness or injury because they have no health insurance at all.

And it has been a year in which health costs have gone completely out of control, with physician fees escalating 40 percent faster than other items in the Consumer Price Index and hospital charges soaring 105 percent faster, while the hospital placed the blame on their own employees whose wages still averaged under $7,800 per annum in all hospitals and at the poverty level of $5,800 in small hospitals.

Mr. Chairman, these are the types of problems with which your committee must deal, and not merely the problem of which new financial patch to apply to a defective and already overcostly health care system. These are the problems which even the administration has noted, and ignored on grounds that the Federal budget can absorb no new spending programs.

Placing total reliance on the failing private insurance industry to solve our health care crisis, the administration 11 months ago shelved for a year its own national health insurance plan. Whether or not the shelf life will be extended is not yet clear. What is clear is that the problems which caused an initial, if tardy, administration response have not been solved and, indeed, have been more fully exposed to public view.

Sometimes it seems that the medical and medical insurance bureaucracies have ruled out compassion in dealing with people, but it is the fearful cost of health services that, rightly, draws most attention to the problems.

When the Committee for National Health Insurance was organized in 1968, Federal, State and local governments spent $20 billion for health purposes. Last year, costs of the same services escalated to $41 billion. Two years from now, the governmental budgets will be emptied of over $55 billion for health care unless changes are made in the system. Total costs, private and public, now are an estimated $118 billion annually and consume 8.3 percent of the GNP versus $54 billion and 6.5 percent of GNP in 1968.

It is, therefore, not a question as to whether the Congress should delay action on the issue of health care. The crisis has moved to such a stage that you will have no choice but to provide for an inordinate number of additional billions of dollars or say to the elderly and the poor, "We'll have to take back what we've given you."

The illness that afflicts the health care system is now generally diagnosed. In order to provide effective treatment, it should be clear that each of the causes must be dealt with, and dealt with concurrently.

Unfortunately, all but one of the major bills before your committee, Mr. Chairman, choose to ignore most of the causes or even the symptoms of the illness.

An example is the plan developed by the American Medical Association, which resembles the previous Nixon and Ford plans. While it is generally agreed today that every American should have health insurance coverage, the AMA insists that coverage must be voluntary and not universal—or as they call it, "compulsory."

This bill (H.R. 6222) asks you to pass a law to mandate employers to offer second-rate private health insurance policies, purchased from carriers of the employers' choice, to all employees. However, the employee could be required to pay 35 percent of the premium costs. The marginally employed and the low-income employer would be reluctant to pay about $350 a year for their share of the insurance. Many could not afford it. Others would not want it after they examined the policy and found that they and their families would still be liable for up to $2,000 per year in coinsurance payments, or up to $1,500 if they were single. Many services would be limited, others excluded entirely.

The AMA bill is typical of others which would mandate employer-employee insurance. These bills provide for the most inequitable financing of services. An employee earning $6,000 per annum would pay as much as an executive earning $60,000.

Since the AMA bill is totally lacking in cost controls, even greater escalation of medical costs than at present would occur should this approach be enacted.

Since quality controls would be absent and more dollars available, even greater incentives would be provided for overutilization, overprescribing and unnecessary surgery.

Mr. Chairman, doctors are not ogres. We believe that the large majority of physicians are dedicated, hard-working, competent and concerned individuals. Our quarrel is not with our doctors. Our quarrel is with a system which corrupts its own members and fails to meet the needs of the people—with a system which produces too few doctors, rewards inefficiency and ineffectiveness, leaves millions unserved in rural America and the inner cities and forces consumers to pay astronomical amounts for episodic care.

The AMA bill would not remove patient frustration which plague the doctor-patient relationship.

It would only extract higher fees from patients and make solo practice, fee-for-service even more rewarding for doctors than at present.

In the health security bill (H.R. 21) which we support, provision is made to continue the fee-for-service system, but to introduce essentially needed controls on the cost and quality of the services delivered under this system.

Early in this century, in a preface to his book, "The Doctor's Dilemma," George Bernard Shaw wrote:

> That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity.

Those who believe that progress must be made incrementally regard the Long-Ribicoff catastrophic insurance plan as an acceptable response to the health care crisis. We believe, however, that this bill has serious and even fatal flaws.

While the bill lacks any provision for representation of the consumer, it is clear that it would greatly strengthen the position of the private insurance companies.

A $30 billion industry which has failed to provide universal coverage, failed to control medical costs, failed to assure quality and which has insured great success to date in defeating real national health insurance proposals would be further enriched by the Long-Ribicoff bill.

By law, the major share of the estimated $8.9 billion additional first year costs of the program would flow through the insurance industry, which already retains $4 billion for its operating expenses and profits in ineffectually administering current health insurance plans.

We have provided in appendix A, case histories of people who would not be helped by catastrophic insurance.

[Appendix A follows:]

APPENDIX A

CASE HISTORIES

Among the people who would not be helped by Catastrophic Insurance is the elderly gentlemen who called our office in Anaheim, California, with this problem:

(1) "I don't want to be a nuisance but I have had a stroke and the doctor I have been going to will not take Medicare and I was advised to get another doctor. I have called everywhere I know of, and I can't possibly get a list of the doctors in this area who will accept Medicare. Can you help me?"

One must ask whether the Medicare model is the one we wish to build upon as does the Long-Ribicoff bill.

(2) Another who would not be helped is the man who was being carried into the Westminster Hospital, Westminster, California. He was pleading with the two attendants carrying him not to take him into the hospital because he had no way to pay the bill.

The attendants told him he must go in, "you are having a heart attack and this is the nearest hospital."

As the man disappeared into another room, he was still pleading, "Don't take me in here. I have no money to pay the bill and if I die, my wife will be stuck with a burden she cannot handle."

The other people Catastrophic insurance won't help?

The following cases described are real. They were among hundreds of stories told to the Senate Health Subcommittee. Only the names have been changed.

(3) Mr. Simmons, a spray painter, and his wife. Within ten months after the delivery of her first child, Mrs. Simmons had a tubal pregnancy requiring hospitalization twice for surgery. Although both hospitalizations were relatively short, each time Mrs. Simmons was released earlier than was medically advisable because the Simmons' did not have enough money to pay the hospital bill. As a result, Mrs. Simmons suffered a serious relapse and then was denied readmittance to the hospital insurance.

"I was working at Easterly Corporation at the time and they went out of business. I had insurance through them and we were told our policy was good for 90 days after the company folded. I was out of work a month and a half when my wife went to the hospital. Then we found out we didn't have any insurance."

"I had $3,200 worth of medical bills not covered by insurance—that was hospital bills, doctor bills and drugs. I was paying $20 a month and I was making $70 a week. I dropped down, I finally was not paying anything because I couldn't afford it. Then they turned it over to the collectors and they garnisheed my wages. I had to declare bankruptcy . . . to get out from under the pressure of the doctors and the collectors."

> Catastrophic insurance requires 60 days of hospitalization in a year before it begins to pay any hospital costs. It requires the expenditure of $2,000 on "covered" medical services (excluding such high cost items as drugs) before it begins to pay any medical expenses. The cost of the first 60 days of hospitalization cannot be applied toward the $2,000 deductible.
>
> The Simmons' could not raise enough money to afford two *short* hospitalizations—much less 60 days. Most of their catastrophic insurance would not have helped with the doctor bills either.

Mrs. Drake, a mother of five. Mrs. Drake had five unwanted pregnancies in eight years. She was unable to tolerate birth control pills and the local hospital and surgeon refused to perform a tubligation unless she posted cash in advance. The Drakes cannot afford routine medical care of preventive health services. They must limit doctor and hospital visits to emergency situations. Even so, there are insurmountable barriers to even emergency care. At one city hospital they must pay $75 in advance before receiving treatment, at the other, the price is $50.

"My husband told me one time when I was pregnant, 'I don't like children. Ours have always been sickly, we watch them almost die because we have no money.' It just tears us apart to have them." One winter when Mr. Drake was out of work their third child developed rheumatic fever. Mr. Drake's unemployment compensation was $36 a week, out of which they had to pay $12 each week for the child's medicine. Their second child suffers from bronchial asthma which frequently develops into pneumonia. Once, after being taken to the emergency room of a local hospital, the child was refused oxygen until Mrs. Drake could raise $50. Mr. Drake had just started a new job and they had to borrow that money from his boss

Even when Mr. Drake's job provided a group health insurance policy, it was no help. Mrs. Drake needed an operation. They did not have enough cash for the surgeon, and the insurance company refused to make any payments on their behalf claiming that they must first pass through a two-year waiting period without submitting claims since "there are too many bad risks in the family."

The specialist refused to operate unless he was paid cash. So, while Mrs. Drake was hospitalized, a local General Practitioner offered to loan the family the money. But the morning of the scheduled surgery, the family doctor died. "The specialist came in and gave me a hypo in the arm and I thought they were getting me ready for the operation. Fifteen minutes later he said, 'Your source is gone, it just died. You either come up with the money or get out of the hospital'. The next day I left the hospital."

> Catastrophic insurance would not help the Drakes. Even if they were covered, the drugs required by their child with rheumatic fever would be excluded from payment under the program, the routine medical care and emergency room services required by the children would not be covered until $2,000 had been paid out—the Drakes don't begin to have that amount of money. And the short hospitalization and moderate surgical fee required for Mrs. Drake's tubligation would not meet the deductible required under catastrophic insurance. Although Mr. Drake's employer would be forced to pay Catastrophic Insurance tax whenever he was employed, this family in such desperate need of care could never hope to collect under the program.

Jose Garcia, a young migrant worker. Jose, an 18 year old migrant, travels with his mother, sisters and brothers between the migrant work camps. Last year he was shot in the thigh when leaving a dance hall. Friends rushed him to the local hospital. The hospital refused him treatment until $200 was posted. It required several hours for Mrs. Garcia and Jose's friends to raise the necessary money from other migrants. Only then was Jose given medical care.

Mrs. Garcia was informed several days later that her son required additional surgery to repair the damage created by the gunshot wound. Again, she was forced to raise the cash before the doctor would treat Jose.

> Catastrophic health insurance would offer no help to the Garcias. Even if they had been eligible, catastrophic insurance would not have helped Jose get into the emergency room any faster—cash in advance would still have been required. Nor would it have paid any of the $500 hospital bill.

(6) Mrs. Williams, the wife of a grocery store checker. Mrs. Williams has had actinomycosis, an incurable fungus germ in the bone marrow, for over 20 years. She has been in and out of the hospital and is currently on full sulfa drug medication. Lab tests must be run approximately once a month and sometimes more frequently. Each series costs about $50. Her medicine runs about $40 per month.

Her husband is a checker for a chain grocery store. His annual salary is under $11,000 and he is covered by a health insurance plan through his union.

"We have spent approximately $75,000 over the last 20 years and we have paid approximately one-third of this out of our own pocket. Some years our medical and drug bills run over $2,000. My life has been a financial nightmare. I have lost my life insurance because I borrowed so much on it that it was useless to pay it back; so I let it go."

> Even with bills as astronomical as Mrs. Williams', catastrophic insurance wouldn't help. She has never required 60 days of hospitalization in any one year. Most of her expenses come from the cost of drugs, which aren't covered under catastrophic insurance and doctors bills, which seldom exceed $2,000 in any one year.

(7) Mr. Mason, a skilled craftsman. Mr. Mason, 52, has been a self-employed skilled craftsman for most of his working life. He has no private health insurance. "In 1963, the insurance company salesman approached us about buying hospitalization and I bought it for me and my family. But on examination, they found that I suffered from high blood pressure. That was the first time I knew it. From then on I could not get any hospitalization insurance.

Mr. Mason suffered a coronary occlusion and was hospitalized for 15 days. "On the day of my release we received the bill to that date which was $1,500 for the hospital expenses plus $150 for the doctor bill." His wife withdrew all of their savings out of the bank. "I had actually saved $4,000—it had taken 12 to 15 years. I had raised two children. They are now grown and on their own. We spent part of the money the previous summer to move and to buy household appliances. Then when this illness came, the entire bank account was wiped out. I haven't been able to add to it. I am just barely getting back to work now."

> Catastrophic insurance wouldn't help Mr. Mason. His 15 days of hospitalization don't come close to the 60 days required before expenses are paid.

(8) Mrs. Jones the mother of five. Each of her four sons was born with a hernia which required surgery. The cost was $250 for each operation. In addition, one of the boys had asthma requiring eight weeks of hospitalization in one year. For five weeks he required daily injections of a special medication not covered by Blue Cross. The medicine cost $15 and the doctor charged $10 for giving the injection.

"Just with doctor bills and medicine bills for the one boy it was over $3,000 that my husband and I had to pay. It got to the point where we couldn't pay and keep up with the other bills too. We were forced to file bankruptcy which was very sad. We lost everything. It humiliated my husband—made him feel like a nobody. The financial hardship created friction in our family. There was constant fighting and as a result, we are now separated. I had to go on welfare."

> Catastrophic insurance would give scant assistance to the family. Their son's long hospitalization lasted 54 days—six days short of the point at which catastrophic insurance would begin to pay 80% of the bill. Their $525 in drug bills are not covered benefits under catastrophic. Their medical bills totalled about $2,600—of which catastrophic insurance would have paid $480. It is doubtful that $480 would have saved this family from bankruptcy.

(9) Mrs. Adams, a former Federal employee. Mrs. Adams worked for the Federal Government for more than 17 years before she was stricken with severe pneumonia and thrombophoebitis in 1964. She required emergency hospitalization and more than 36 tanks of oxygen. The attack left her so completely disabled that she was forced to retire on partial disability payments.

Mrs. Adams' income dropped from $6,000 per year to $1,020 per year. Mr. Adams, also in precarious health, became totally disabled too.

We panicked. We lost our home, our lovely car and were forced to move to a very undesirable part of the city. . . . I did not take this as a permanent thing. I felt it had to be temporary. Each year I pushed myself and pushed myself and would try to return to work.

I had Blue Cross as a Federal employee and I have never understood why I ended up owing so much money. We tried to spread our income across the board. This was impossible. It forced us into bankruptcy. We felt a deep moral obligation to the people who had trusted us, so we divided our money, split it up and gave each of them some. This way we have been able to keep our furniture, but that is all.

I find that I am playing a game I can't win. We still have an anesthesiologist and a dental bill, we have internal medical man to pay and sometimes I wonder how in the world; how can we win? I have bills now of about $400. It is a lot of money to a family with an income like ours. To me, $400 is a catastrophe.

Mr. WOODCOCK. Mr. Chairman, catastrophic health insurance won't help people because it is based on a myth. The myth is that people already have good basic coverage but require protection only against catastrophic illness. The reality is that people do not have good basic coverage. Some do, most do not. In its "Forward Plan for Health," even the administration concedes this point, as follows:

> The fact that most of the insured population has inadequate benefits is . . . troublesome. Most basic insurance policies exclude preventive care services, ambulatory care, and prescription drugs and medical devices, and many policies still exclude pre-existing conditions and congenital defects. In addition, many policies include only limited coverage of other necessary services, such as mental health care. The usual protection against medical and financial catastrophes is also inadequate. About half of private policies limit total benefits in a lifetime to $10,000 or less, and almost two-thirds of current policies limit hospitalization to 60 days or less.

In other words, catastrophic insurance would be like building an archway with no foundation. Most people would be wiped out long before the trigger point for any benefits. Mostly the rich would benefit—rich providers, rich insurance executives and rich patients. Working people would pay the bills.

Catastrophic health insurance has deductibles of 60 hospital days and $2,000 in physician fees and medical expenses. This is a bill with a deductible of $11,500.

Catastrophic health insurance will not provide any benefits at all to 99.5 percent of the American people, but it sounds good.

Mr. Chairman, there are other important reasons why we would oppose catastrophic health insurance as an alternative to comprehensive health insurance.

It would create greater imbalance and inflation in the health care system by adding to incentives for very expensive care and disincentives for preventive care.

It would invite providers of services to raise prices, especially for the seriously ill and dying, on the excuse that the family or individual would thereby become eligible for catastrophic benefits. The net result would be a price rise in all aspects of health care.

It would create incentives for longer hospitalization and other institutional care.

It would further skew manpower away from rural and small town areas by increasing the funds available to pay lucrative specialists in the urban areas.

It would increase the cost of medicaid and medicare and other Government programs. By pouring more money into the private sector, it would cause simultaneous acceleration of costs of public programs to occur.

We have provided in appendix B comments on title II of the Long-Ribicoff bill.

[Appendix B follows:]

Appendix B

Federalized Medicaid

There is another section of the Long-Ribicoff bill which would federalize Medicaid and establish an elaborate means-test system not only for the poor but also for families with average incomes who could "spend down" to the $4,800 limit for entitlement to the poor part of the program.

We, of course, cannot support a second-class medical care system, and would strongly oppose means-tests in any form as a requirement for the receipt of necessary medical care.

Subsidies for families would be rated according to both income and family size, and benefits under the government program would have to be checked against any private health insurance, and reduced accordingly.

This program would employ an army of clerks and gumshoes to detect medical deadbeats seeking to beat the system by having unnecessary operations at low cost. Wouldn't it be wiser to use the same money to encourage health maintenance and preventive medicine?

The lessons that we have learned in the SSI program should not be ignored in legislating a national health insurance program. Means-tests are cumbersome, onerous, difficult to administer, faulty, often incomprehensible, degrading and create unnecessary make-work costing hundreds of millions of dollars annually.

Just imagine the case of a young couple with a small child. He earns $80 a week as an apprentice mechanic.

He declines to join his employer's health insurance plan since they can't afford his $12 a week share of the premium cost. They are eligible for the Medical Assistance Plan since their annual income is under $4,200. The baby catches a cold and they take her to the doctor. Later, she seems to be colic. There are ten physician visits in all. Each time they pay $3 as co-payment charges. The baby is cured and is taken to the doctor for well-baby care, which requires no co-payment. The father receives a pay raise to $90 a week. The family thus exceeds the income limits for the coming year. However, the mother becomes pregnant again and, with the birth of the new baby, they are again eligible since the income limit is increased to $4,800 for a four-person family—and $5,200 for a five-person family, $5,600 for a six-person family, $6,000 for a seven-person family.

However, the good news of the arrival of the new bay is tempered by the bad news that government investigators found out that the father had declined the employer health insurance plan. Therefore, the family must pay $250 of the maternity costs. Later, however, the young father completes his apprenticeship and receives a raise to $150 a week. Fortunately, costs of the broken leg he suffers while playing football with his neighborhood friends are to be fully covered under the Medical Assistance Program after he has spent $2,700—or has "spent down" to $4,800 from his new annual income of $7,500. Fortunate also that his increased taxes will support the clerks needed to make this system go and the sharply higher physician fees and hospital charges that will feed off the program.

Mr. Woodcock. Mr. Chairman, we are convinced as are a majority of the American people, that our Nation needs a universal, comprehensive national health insurance program. This country is one of the two or three top spenders on health care in the world. Yet, the United States is the only industrialized nation in the world that does not have a national health program for its people.

We do not need to spend more money; we are already spending too much. And we know from direct experience in our own union that the cost problem is getting worse and worse.

Let me put it to you in terms of the average auto worker in Michigan whose family health insurance premium amounts to somewhere over 1 month's wages—moneys he could have in the pay envelope if it were not diverted for this high priority need. According to estimates of the Department of Health, Education, and Welfare, unless there is intervention in the system, by 1980 he will have to forego 2 months' wages for the same benefits. We need to ask ourselves and we need to ask our elected representatives in the Congress whether this is a situation this Nation can continue to tolerate. Similarly with medicare and medicaid. The OMB estimates that costs which totaled $10 billion in 1970 will increase to $25 billion in fiscal year 1976 and will total $52 billion in fiscal year 1981.

Unless this committee and this Congress does something about the health care system, there is no escaping the fact that you will have to provide $27 billion more for the same inadequate health programs we have today.

But it would be wrong to look only at the dollar sign in terms of health care. It would be wrong to emphasize only that this country spends far more per capita on health care than any other nation in the world and that by most of the accepted indexes of health studies we lag behind almost every other industrialized or semi-industrialized nation.

We need to look at the quality of the care we are getting. We need to ask ourselves whether the many studies and reports of needless surgery should produce action programs to correct the situation. We should be deeply disturbed by the large numbers of us who end up in hospitals each year as a result of reactions to prescribed drugs—some estimates indicating that as many as 80 percent of these reactions could have been avoided. We need to worry when we are told that as many as 30 percent of all the X-rays taken are either inaccurate or unreadable. We should be demanding far more aggressive measures to see to it that the large numbers of inaccurate or even wrong findings of laboratory tests are reduced sharply and possibly eliminated entirely. How on earth can we expect to get adequate treatment from the health care system if it is based on faulty tests?

If we enact a national health plan which will generate real reforms, we can preserve the best in our present system and replace its worst features.

Those who favor incrementalism completely abandon cost and quality controls and systems improvements. Unless these are built into any plan, the plan will do nothing but exacerbate the problems it is trying to correct.

Incrementalism has been the approach which we have followed in the United States in the last 30 years. It is precisely this approach which has led us to the sad state of affairs in health today. The health security program through seeing all of the problems in relation to each other, and through using the leverage of large funds coming into the system, proposes to begin to integrate the necessary corrective measures in restructuring the system. It is admittedly evolutionary and it will take time to produce progressive change. But it sees the problem as a whole and deals with it in like manner.

Delivering health care to every American depends on the development and organization of the available resources, and an equitable financing system. It depends on the leverage and support of a national health insurance plan which will create the resources and provide the leverage needed for reforms. Health security alone meets these standards.

Many national organizations—religious groups, labor, senior citizens, health professionals and others—have endorsed the principles of the Health Security Act as essential to the legislation you are considering. The first of these principles is health care as a right, unabridged by any means tests, work earnings tests or any other requirements.

We believe that the legislation enacted must:

Provide universal coverage, under one system.

Provide for comprehensive health care services, including preventive care as well as diagnosis, treatment and rehabilitation.

Provide payment in full for all costs of covered services, including the extraordinary costs of catastrophic illness.

Finance all covered services through a trust fund based on payroll taxes and general revenues, administered by the Federal Government.

Contain strong quality control mechanisms.

Establish prospective reimbursement of providers to control costs, eliminate duplication and reduce waste.

Assure effective consumer participation and public accountability.

Provide resources, development and distribution in a system responsive to community needs.

Of the bills before your subcommittee, Mr. Chairman, only the Health Security Act measures up to these essential principles.

The question of costs was well answered by Dr. Rashi Fein, professor of economics at Harvard Medical School when he said, "New parks, roads or bombers represent money for things the people would otherwise not have. But medical care is different; we are already spending $104 billion, and private expenditures account for $63 billion of that total.

"So the issue is a nonissue. The question can we, as a people, afford national health insurance, really means can we afford to spend what we are already spending—and surely the answer is 'yes'."

Understandably, this subcommittee is concerned about costs to the Federal budget, as well as costs to State and local governments, and to the family budgets.

Our consulting actuary has prepared an analysis of comparative costs of national health insurance programs for future years. Using the methodology developed by the administration, including some assumptions with which we would not necessarily agree, the analysis shows nevertheless that H.R. 21 would, within 4 years, actually save $21 billion annually in national health expenditures in comparison with the catastrophic insurance program. It would save $25.5 billion in comparison with the administration's own CHIP plan, which served as the blueprint for the new AMA bill. And it would save $11.6 billion in costs which would otherwise occur as a result of doing nothing.

The reasons for the savings are not complex. Under the health security bill, all costs would be anchored to budgets prepared and approved in advance. Under H.R. 21, system reorganization would be encouraged, with the concomitant savings in hospital utilization and provider costs which result from the team approach to the delivery of comprehensive benefits. Under other bills, payments to providers would remain open-ended.

We would like to submit this analysis for the record.

[Appendix C follows:]

APPENDIX C

COMPARATIVE COSTS OF NATIONAL HEALTH INSURANCE PROGRAMS

TOTAL NATIONAL EXPENDITURES FOR COVERED PERSONAL HEALTH SERVICES FOR FISCAL YEAR 1978 AND FISCAL YEAR 1982 (ASSUMING PROGRAMS IN FULL OPERATION)

[In billions of dollars]

	No programs	S. 3/H.R. 21	Administration	Catastrophic
FISCAL YEAR 1978				
Total expenditures	142.3	160.2	151.1	148.3
Through Federal budget	38.7	137.3	53.2	46.4
Social security funds	21.3	62.8	29.5	22.5
General revenues	17.4	74.5	23.7	23.9
Through State/local budget	15.5	4.5	14.1	15.4
Through insurance industry	44.8	4.2	51.5	46.4
Out-of-pocket	41.6	13.6	31.3	38.9
Other	1.7	.6	1.0	1.2
FISCAL YEAR 1982				
Total expenditures	222.0	210.4	235.9	231.4
Through Federal budget	60.4	180.4	83.0	72.3
Social security funds	33.3	82.6	46.0	35.0
General revenues	27.1	97.8	37.0	37.3
Through State/local budget	24.2	5.9	21.9	24.1
Through insurance industry	69.9	5.5	80.5	72.5
Out-of-pocket	64.8	17.9	48.8	60.6
Other	2.7	.7	1.7	1.9
Mechanisms:[1]				
Hospital cost controls		14.8	(7.5)	(5.1)
Physician dentist cost controls		3.3	(3.3)	(2.1)
Other services		(6.5)	(3.1)	(2.2)
Total savings		11.6	(13.9)	(9.4)

[1] Fiscal year 1982 cost savings (cost increases) measured against "No program" resulting from cost-containment mechanisms in each program.

NOTES

1. The primary source for these figures is table 2 from "Estimated Health Expenditures Under National Health Insurance Bills, A Report to the Congress, July, 1974." See page 4. These estimates were projected to fiscal years 1978 and 1982 using the following inflation factors:

	Percent per annum
Hospital costs	15
Doctors and dentists	10
Drugs and drug sundries	5
Other services	8

However, it was assumed that the cost controls in S. 3/H.R. 21 would be effective to reduce costs under that bill from fiscal year 1978 (when 1st effective to reduce costs under these assumptions) to fiscal year 1982 as follows:

	Percen per annum
Hospital costs	8
Doctors and dentists	5
Other	Same

2. Induced costs included in the HEW study were distributed among the various categories of services in each of the programs in proportion to expenditures found in table 2 for fiscal year 1975. "Total" column. Thus, the projected costs include induced costs.

3. The projected costs were then distributed by source of financing, using the percentage distribution found in table 3 of the HEW study. No effort was made to adjust the projected figures to reflect the likelihood that, because hospital costs are more heavily insured than other health care expenditures, the percentage distribution would change somewhat over the years under the assumed inflation factors.

Mr. Woodcock. With respect to the program costs of health security, Dr. Falk has updated the figures previously given to the Ways and Means Committee as a result of the astronomical increases in health costs which have occurred without health security. They are outlined in appendix C of this statement.

Mr. Chairman, we feel the evidence is clear both in our own social security program and in the Canadian national health insurance program that administrative costs of national health insurance would be reduced by a health security-type program in comparison with the present system of hundreds of insurance companies, each with its own sales force, claims department, reserves, profits, and battalions of underwriters and clerks.

Mr. Weinberger, the former Secretary of HEW, testified before this committee last year that 45,000 to 49,000 additional employees would be required to administer H.R. 21. However, the chairman of the board of the Equitable Life Assurance Society of the United States has stated that 300,000 private health insurance employees would be put out of work if the Health Security Act were to be enacted. While I would be the last to wish to add to the unemployment rolls, we must surely ask whether we can continue to subsidize with limited numbers of health care dollars the tremendous operating and administrative expenses of the health insurance industry.

Those who believe that the best defense is a strong offense will continue to degrade the performance of the Social Security Administration.

The disclosures about SSI overpayments have strengthened the hand of those who would play on the public's concern about one more giant bureaucracy. Overpayments make headlines; causes of the problem are buried inside the newspapers.

This subcommittee is aware of the causes of the SSI situation—a large program superimposed by political appointees upon an efficient agency which is denied the manpower required to administer it, given 11th hour orders changing essential characteristics of the program, and encumbered with deficient State data.

The problem is not that the Social Security Administration is inefficient or callous to public concerns about the expenditure of public funds. Social Security is a model of efficiency whose management practices could well be replicated by private insurance companies.

The problem is not that a new program recruited too many new employees to staff it. Too few are allowed by the political bosses of HEW.

The problem is not that we have a gigantic snafu caused by bureaucracy. The snafu was caused by the political leadership.

It's easy and often politically profitable to criticize governmental bureaucracy, but the members of the Ways and Means Committee know full well that the Social Security Administration suffered no SSI-type snafus as long as its programs were run by dedicated public administrators and not politicians.

In conclusion, Mr. Chairman, let me say that we very much appreciate the initiatives you have taken in moving forward with these hearings and in seeking reasonable solutions to the problem of congressional committee jurisdiction on the issue of national health insurance.

We appreciate the hard work you have undertaken and the personal commitment you have made to achieving a national health insurance plan which will benefit every American.

Mr. Chairman, we thank you for the opportunity to present our views and are ready to answer questions about our testimony. As a group, we are prepared to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF LEONARD WOODCOCK IN BEHALF OF HEALTH SECURITY ACTION COUNCIL, AND INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW

Mr. Chairman, members of the Health Subcommittee. My name is Leonard Woodcock and I appear before you today on behalf of the five million members of the United Auto Workers' families, and the 80 national organizations which comprise the Health Security Action Council. The members of these organizations number in the millions and represent a broad cross-section of American life. I understand that your Committee will take testimony directly from State and local representative groups of the Health Security Action Council later on in these hearings, and we commend you for opening your hearings to the people who will be most affected by what you do here.

With me today are Dr. I. S. Falk, Professor-Emeritus of Public Health, Yale University, who is Chairman of the Technical Committee of the Committee for National Health Insurance; Melvin A. Glasser, also a member of the Technical Committee and Director of the UAW Department of Social Security; and Max W. Fine, Executive Secretary of the Health Security Action Council.

Mr. Chairman, we are here to testify in support of the Health Security Act (H.R. 21) and about other health care proposals under consideration. We have already testified extensively before the Ways and Means Committee and two Committees of the United States Senate about why we support the Health Security Act. We are grateful to the more than 100 members of this body who are co-sponsoring this important and inevitable legislation. We stand for Health Security. We have fully put into the record why.

We have testified as to what Health Security is and what it is not. We have shown how it will produce urgently-needed changes in the health care delivery system. We have discussed its quality control features, the needs for which are growing even faster than malpractice insurance premium increases. We have provided data about its costs, cost controls and cost saving features, and we will continue to update these data and not be intimidated by those who are deliberately misinterpreting the costs of Health Security.

Your Committee has not yet acted on this urgent problem, but we have hope that the new round of hearings which you are now undertaking will finally produce a Health Security program for all Americans. We support your undertaking and we offer our assistance in helping you to clarify the issues so that your actions will be based on the facts as they exist and not on the imagination and distortions of Madison Avenue hucksters employed by the vested interests. As the problems have grown, so too have their efforts to convince us that no problems exist.

KEY ISSUES

As a result of the Administration's totally incomprehensible position on this issue, not much attention has been paid to the health care problems of the American people in the past year. However, it has been a year in which the health care crisis has grown worse.

The problems of poor distribution of services, shortages of family physicians, and duplicated, disorganized and excessively high cost of services have all intensified.

It has been a year in which millions of American families played Russian Roulette with the lives and health of their children—a year in which 5.3 million of our 13.2 million preschool children were unprotected against the killing and crippling infectious diseases: polio, measles, rubella, diphtheria, whooping cough and tetanus.

It has been a year in which one-third of all pregnant women who delivered in public hospitals had no prenatal care and consequently ran high and unnecessary risks to themselves and their babies.

It has been a year in which millions of America's laid-off workers joined both the lines at the Unemployment Office and the swollen ranks of 40 million Americans who face disaster in the event of even a short acute illness or injury because they have no health insurance at all.

It has been a year of doctor strikes, public hospital overcrowding, private hospital and nursing home profiteering, and scandalous abuse of the weakest and least able of our senior citizens.

And it has been a year in which health costs have gone completely out of control, with physician fees escalating 40 percent faster than other items in the Consumer Price Index and hospital charges soaring 105 percent faster, while the hospitals placed the blame on their own employees whose wages still averaged under $7,800 per annum in all hospitals and at the poverty level of $5,800 in small hospitals.

Mr. Chairman, these are the types of problems with which your Committee must deal, and not merely the problem of which new financial patch to apply to a defective and already over-costly health care system. These are the problems which even the Administration has noted, and ignored on grounds that the Federal budget can absorb no new spending programs.

While we should be reaching out to assure that every child has access to immunizations, and the family the means to pay the costs, the Administration wants to tighten up and shift even part of the meager existing Federal support for these services to the States and to the family budgets. The Administration's policies would divert minimal Federal amounts in prevention and cause billions in the treatment costs to the States and families in future years. They would throw millions of additional Americans on to the medical dole.

Health is a great aspiration of the American people, but the budget cutters in the Administration suffer from severe buck fever when we face serious health problems. Although it has finally promulgated regulations on dual choice under the HMO legislation signed into law 20 months ago, the record is one of indecision and over-reliance on the private sector to which the Administration itself constantly offers magnificent opportunities for inaction.

Placing total reliance on the failing private insurance industry to solve our health care crisis, the Administration 11 months ago shelved for a year its own national health insurance plan. Whether or not the shelf life will be extended is not yet clear. What is clear is that the problems which caused an initial, if tardy, Administration response have not been solved and, indeed, have been more fully exposed to public view.

Sometimes it seems that the medical and medical insurance bureaucracies have ruled out compassion in dealing with people, but it is the fearful cost of health services that, rightly, draws most attention to the problems.

When the Committee for National Health Insurance was organized in 1968, Federal, State and local governments spent $20 billion for health purposes. Last year, costs of the same services escalated to $41 billion. Two years from now, the governmental budgets will be emptied of over $55 billion for health care unless changes are made in the system. Total costs, private and public, now are an estimated $118 billion annually and consume 8.3 percent of the GNP versus $54 billion and 6.5 percent of GNP in 1968.

It is, therefore, not a question as to whether the Congress should delay action on the issue of health care. The crisis has moved to such a stage that you will have no choice but to provide for an inordinate number of additional billions of dollars or say to the elderly and the poor, "We'll have to take back what we've given you."

In their recent national poll, the Cambridge Survey found that only 13 percent of the American people felt the present health care system was functioning relatively well, while 57 percent demanded a total national health insurance program as provided in the Health Security Act or even a complete Federal takeover of the entire system with doctors placed on salaries.

The depth of public dissatisfaction should be underestimated only at one's political peril, even though health may not command the urgency of the problems of the general economy and unemployment.

Federal employees will receive phantom pay raises next January because of 35-to-45 percent higher health insurance premiums which threaten to wipe out most of the five percent wage increase.

The situation is no less disturbing in the private sector where higher premiums also mean lower wages. We all purchase health services in the same sellers' market, and the prices there are completely out of control. To the extent that health care costs and health insurance premiums continue to absorb more of the hard-earned dollars of the American worker than of his foreign counterpart, the competitive position of American business and industry will continue to be weakened. Jobs as well as paychecks will be cut.

THE AMA BILL

The illness that afflicts the health care system is now generally diagnosed. In order to provide effective treatment, it should be clear that each of the causes must be dealt with, and dealt with concurrently.

Unfortunately, all but one of the major bills before your Committee, Mr. Chairman, choose to ignore most of the causes or even the symptoms of the illness.

An example is the plan developed by the American Medical Association, which resembles the previous Nixon and Ford plans. While it is generally agreed today that every American should have health insurance coverage, the AMA insists that coverage must be voluntary and not universal—or as they call it, "compulsory."

This bill (H.R. 6222) asks you to pass a law to mandate employers to offer second-rate private health insurance policies, purchased from carriers of the employers' choice, to all employees. However, the employee could be required to pay 35 percent of the premium costs. The marginally-employed and the low-income employed (for example, those hospital employees with incomes of only between $5,800 and $7,800 per annum) would be reluctant to pay about $350 a year for their share of the insurance. Many could not afford it. Others would not want it after they examined the policy and found that they and their families would still be liable for up to $2,000 per year in co-insurance payments, or up to $1,500 if they were single. Many services would be limited, others excluded entirely.

The AMA bill is typical of others which would mandate employer-employee insurance. These bills provide for the most inequitable financing of services. An employee earning $6,000 per annum would pay as much as an executive earning $60,000.

Since the AMA bill is totally lacking in cost controls, even greater escalation of medical costs than at present would occur should this approach be enacted.

Since quality controls would be absent and more dollars present, even greater incentives would be provided for over-utilization, over-prescribing and unnecessary surgery.

Mr. Chairman, doctors are not ogres. We believe that the large majority of physicians are dedicated, hard-working, competent and concerned individuals. Our quarrel is not with our doctors. Our quarrel is with a system which corrupts its own members and fails to meet the needs of the people—with a system which produces too few doctors, rewards inefficiency and ineffectiveness, leaves millions unserved in rural America and the inner cities and forces consumers to pay atronomical amounts for episodic care.

The AMA bill would not remove patient frustrations which plague the doctor-patient relationship.

It would only extract higher fees from patients and make solo practice, fee-for-service even more rewarding for doctors than at present. Health care would for the foreseeable future be locked into this corrupting system which lies at the root of many malpractice actions. Abuses would be ignored.

In the Health Security Bill (H.R. 21) which we support, provision is made to continue the fee-for-service system, but to introduce essentially needed controls on the cost and quality of the services delivered under this system.

Early in this century, in a preface to his book, "The Doctor's Dilemma," George Bernard Shaw wrote,

"That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity."

LONG-RIBICOFF BILL

Those who believe that progress must be made incrementally regard the Long-Ribicoff Catastrophic Insurance Plan as an acceptable response to the health care crisis. We believe, however, that this bill has serious and even fatal flaws.

While the bill lacks any provision for representation of the consumer, it is clear that it would greatly strengthen the position of the private insurance companies.

A $30 billion industry which has failed to provide universal coverage, failed to control medical costs, failed to assure quality and which has enjoyed great success to date in defeating real national health insurance proposals would be further enriched by the Long-Ribicoff bill.

By law, the major share of the estimated $8.9 billion additional first-year costs of the program would flow through the insurance industry, which already retains $4 billion for its operating expenses and profits in ineffectually administering current health insurance plans.

We have provided in Appendix A, case histories of people who would not be helped by catastrophic insurance.

Mr. Chairman, catastrophic health insurance won't help people because it is based on a myth. The myth is that people already have good basic coverage but require protection only against catastrophic illness. The reality is that people do not have good basic coverage. Some do, most do not. In its "Forward Plan for Health," even the Administration concedes this point, as follows:

"The fact that most of the insured population has inadequate benefits is . . . troublesome. Most basic insurance policies exclude preventive care services, ambulatory care, and prescription drugs and medical devices, and many policies still exclude pre-existing conditions and congenital defects. In addition many policies include only limited coverage of other necessary services, such as mental health care. The usual protection against medical and financial catastrophes is also inadequate. About half of private policies limit total benefits in a lifetime to $10,000 or less, and almost two-thirds of current policies limit hospitalization to 60 days or less. In addition, virtually all policies have no upper limit on the amount of cost-sharing a patient is responsible for, regardless of how much has already been spent."

In other words, catastrophic insurance would be like building an archway with no foundation. Most people would be wiped out long before the trigger point for any benefits. Mostly the rich would benefit—rich providers, rich insurance executives and rich patients. Working people would pay the bills.

Catastrophic health insurance has deductibles of 60 hospital days and $2,000 in physician fees and medical expenses. This is a bill with a deductible of $11,500. (It is only in the rare situation that a patient would incur $2,000 in physician insurance fees in a year without a period of hospitalization).

Catastrophic health insurance will not provide any benefits at all to 99.5 percent of the American people, but it sounds good—like the organ grinder whose playing was supposed to soothe the people buried alive by the earthquake debris.

Mr. Chairman, there are other important reasons why we would oppose catastrophic health insurance as an alternative to comprehensive health insurance.

It would create greater imbalance and inflation in the health care system by adding to incentives for very expensive care and disincentives for preventive care.

It would distract the Congress and the public from serious consideration of a comprehensive national health insurance program on the theory that the most serious problems were being dealt with by providing coverage for catastrophic expenses.

It would invite providers of services to raise prices, especially for the seriously ill and dying, on the excuse that the family or individual would thereby become eligible for catastrophic benefits. The net result would be a price rise in all aspects of health care.

It would create incentives for longer hospitalization and other institutional care. There would be tremendous pressure to keep the patient in the hospital until the trigger point for catastrophic was reached.

It would weaken efforts to institute quality controls since catastrophic coverage would not take effect until after the 60th day of hospitalization (and consequently any controls written into the bill could not be instituted until after the 60th day of hospitalization).

Because of the high deductibles and the overwhelming emphasis on major illness, it would further distort the allocation of national health care resources, turning them further away from health maintenance, early diagnosis of disease, home health care, and other neglected aspects of the system.

It would strengthen the hand of the commercial insurance companies vis-a-vis national health insurance.

It would aggravate the maldistribution of services caused by economic factors since the major beneficiaries of catastrophic coverage would be those who are able to spend the deductible amounts.

It would further skew manpower away from rural and small town areas by increasing the funds available to pay lucrative specialists in the urban areas.

It would increase the cost of Medicaid and Medicare and other Government programs. (By pouring more money into the private sector, simultaneous acceleration of costs of public programs would occur).

It would increase the fragmentation and complexities of the financing system.

We have provided in Appendix B, comments on Title II of the Long-Ribicoff Bill.

HEALTH SECURITY

Mr. Chairman, we are convinced as are a majority of the American people, that our nation needs a universal, comprehensive national health insurance program. This country is one of the two or three top spenders on health care in the world. Yet the United States is the only industrialized nation in the world that does not have a national health program for its people.

We do not need to spend more money; we are already spending too much. And we know from direct experience in our own Union that the cost problem is getting worse and worse.

Let me put it to you in terms of the average auto worker in Michigan whose family health insurance premium amounts to somewhere over one month's wages—monies he could have in the pay envelope if they were not diverted for this high priority need. By estimates of the Department of Health, Education and Welfare, unless there is intervention in the system, by 1980 he will have to forego two months' wages for the same benefits. We need to ask ourselves and we need to ask our elected representatives in the Congress whether this is a situation this nation can continue to tolerate. Similarly with Medicare and Medicaid. The OMB estimates that costs which totalled $10 billion in 1970 will increase to $25 billion in FY 1976 and total $52 billion in FY 1981.

Unless this Committee and this Congress does something about the health care system, there is no escaping the fact that you will have to provide the $27 billion more for the same inadequate health programs we have today.

But it would be wrong to look only at the dollar sign in terms of health care, It would be wrong to emphasize only that this country spends far more per capita on health care than any other nation in the world and that by most of the accepted indices of health studies we lag behind almost every other industrialized or semi-industrialized nation.

We need to look at the quality of the care we are getting. We need to ask ourselves whether the many studies and reports of needless surgery should produce action programs to correct the situation. We should be deeply disturbed by the large numbers of us who end up in hospitals each year as a result of reactions to prescribed drugs—some estimates indicating that as many as 80 percent of these reactions could have been avoided. We need to worry when we are told that as many as 30 percent of all the x-rays taken are either inaccurate or unreadable. We should be demanding far more aggressive measures to see to it that the large numbers of inaccurate or even wrong findings of laboratory tests are reduced sharply and possibly eliminated entirely. How on earth can we expect to get adequate treatment from the health care system if it is based on faulty tests?

In the interests of "economy", those who would do nothing advocate the incremental or step approach. They acknowledge the problems in health care to which I allude. But they say, "Let's try to get them fixed one by one. We should not try to do it all at once."

Mr. Chairman, creeping incrementalism will not shore up our collapsing health care delivery system. A complete breakdown would be the more likely result of adding catastrophic insurance and other incremental patches to the Medicare and Medicaid models.

The incremental approach is reminiscent to Huxley's frogs. He kept them in a tank and raised the temperature of the water very slowly, only about one degree a day. Within two months the frogs were boiled to death without knowing what was happening to them. If the temperature had been turned up rapidly, they would have jumped out of the water.

If we enact a national health plan which will generate real reforms, we can preserve the best in our present system and replace its worst features. If we add patches, the whole system may go under in a few years.

Those who favor incrementalism, completely abandon cost and quality controls, and systems improvements. Unless these are built into any plan, the plan will do nothing but exacerbate the problems it is trying to correct.

Incrementalism has been the approach which we have followed in the United States in the last 30 years. It is precisely this approach which has led us to the sad state of affairs in health today. The Health Security program through seeing all of the problems in relation to each other, and through using the leverage of large funds coming into the system, proposes to begin to integrate the necessary corrective measures in restructuring the system. It is admittedly evolutionary and it will take time to produce progressive change. But it sees the problem as a whole and deals with it in like manner.

Delivering health care to every American depends on the development and organization of the available resources, and an equitable financing system. It depends on the leverage and support of a national health insurance plan which will create the resources and provide the leverage needed for reforms. Health Security alone meets these standards.

Many national organizations—religious groups, labor, senior citizens, health professionals and others—have endorsed the principles of the Health Security Act as essential to the legislation you are considering. The first of these principles is health care as a right, unabridged by any means-tests, work earnings tests or any other requirements.

No greater observance of the nation's Bicentennial could be imagined than the enactment of a law which will make real the principle that every American has a right to health care.

We believe that the legislation enacted must:

Provide universal coverage, under one system.

Provide for comprehensive health care services, including preventive care as well as diagnosis, treatment and rehabilitation.

Provide payment in full for all costs of covered services, including the extraordinary costs of catastrophic illness.

Finance all covered services through a Trust Fund based on payroll taxes and general revenues, administered by the federal government.

Contain strong quality control mechanisms.

Establish prospective reimbursement of providers to control costs, eliminate duplication and reduce waste.

Assure effective consumer participation and public accountability.

Provide resources, development and distribution in a system responsive to community needs.

Of the bills before your Subcommittee, only the Health Security Act measures up to these essential principles.

CAN WE AFFORD HEALTH SECURITY?

The question of costs was well answered by Dr. Rashi Fein, Professor of Economics at Harvard Medical School, "New parks, roads or bombers represent money for things the people would otherwise not have. But medical care is different; we are already spending $104 billion, and private expenditures account for $63 billion of that total.

"So the issue is a non-issue. The question can we, as a people, afford national health insurance, really means can we afford to spend what we are already spending—and surely the answer is 'yes'."

Understandably, this Subcommittee is concerned about costs to the Federal budget, as well as costs to State and local governments, and to the family budgets.

Our consulting actuary has prepared an analysis of comparative costs of national health insurance programs for future years. Using the methodology developed by the Administration, including some assumptions with which we would not necessarily agree, the analysis shows nevertheless that H.R. 21 would, within four years, actually save $21 billion annually in national health expenditures in comparison with the catastrophic insurance program. It would save $25.5 billion in comparison with the Administration's own CHIP plan, which served as the blueprint for the new AMA bill. And it would save $11.6 billion in costs which would otherwise occur as a result of doing nothing.

The reasons for the savings are not complex. Under the Health Security bill, all costs would be anchored to budgets prepared and approved in advance. Under H.R. 21 system reorganization would be encouraged, with the concomitant sav-

-ings in hospital utilization and provider costs which result from the team approach to the delivery of comprehensive benefits. Under other bills, payments to providers would remain open-ended.

We would like to submit this analysis for the record, it is in Appendix C.

With respect to the program costs of Health Security, Dr. Falk has updated the figures previously given to the Ways and Means Committee as a result of the astronomical increases in health costs which have occurred without Health Security. They are outlined in Appendix C of our statement.

THE BUREAUCRATIC MYTH

Mr. Chairman, we feel the evidence is clear both in our own Social Security program and in the Canadian national health insurance program that administrative costs of national health insurance would be reduced by a Health Security-type program in comparison with the present system of hundreds of insurance companies, each with its own sales force, claims department, reserves, profits and battalions of underwriters and clerks.

Mr. Weinberger, the former Secretary of H.E.W., testified before the Ways and Means Committee last year that 45,000 to 49,000 additional employees would be required to administer H.R. 21. However, the Chairman of the Board of the Equitable Life Assurance Society of the United States has stated that 300,000 private health insurance employees would be put out of work if the Health Security Act were enacted. While I would be the last to wish to add to the unemployment rolls, we must surely ask whether we can continue to subsidize with limited numbers of health care dollars, the tremendous operating and administrative expenses of the health insurance industry.

Those who believe that the best defense is a strong offense, will continue to degrade the performance of the Social Security Administration.

The disclosures about SSI overpayments have strengthened the hand of those who would play upon the public's concern about "one more giant bureaucracy." Overpayments make headlines, causes of the problem are buried inside the newspapers.

This Subcommittee is aware of the causes of the SSI situation—a large program superimposed by political appointees upon an efficient agency which is denied the manpower required to administer it, given eleventh-hour orders changing essential characteristics of the program, and encumbered with deficient State data.

The problem is not that the Social Security Administration is inefficient or callous to public concerns about the expenditure of public funds. Social Security is a model of efficiency whose management practices could well be replicated by private insurance companies.

The problem is not that a new program recruited too many new employees to staff it. Too few are allowed by the political bosses of HEW.

The problem is not that we have a gigantic SNAFU caused by the bureaucracy. The SNAFU was caused by the political leadership. A director selected by former President Nixon with no experience in this field offered repeated public assurances that the SSI system was ready to go—the machines were in place, the manpower was adequate. After press disclosures of its inadequacies, he blamed the press, saying they were so preoccupied with Watergate that they failed to do their job of ferreting out and exposing the problems at an early stage.

Our Federal, State, and local governments employ millions of people who, Mr. Chairman, are willing to make our system work, if only they are provided the opportunity through quality leadership. They are by and large dedicated and industrious men and women. The leadership which was imposed on HEW over the past few years was another matter. Here was a leadership which was determined to prove itself incompetent, surrounding itself with free-swinging critics of government rather than able administrators, fond of crying out that government was unable to do anything, bent on fulfilling its own prophecy.

It's easy and often politically profitable to criticize governmental bureaucracy, but the members of the Ways and Means Committee know full well that the Social Security Administration suffered no SSI-type SNAFU's as long as its programs were run by dedicated public administrators and not politicians.

Mr. Chairman, I feel sure some of the members are concerned about press reports of the recent GAO analysis of administrative costs under Medicare. As you know, the GAO analysis was undertaken at the request of Chairman Mills in 1973, at a time when the Division of Direct Reimbursement of SSA was in the process of changing its claims reimbursement procedure. Accordingly, the costs per claim paid by the Division of Direct Reimbursement were substantially higher than Blue Cross or the commercial insurance intermediaries in that year.

However, I know you will be pleased to learn, as I was, that the data for the most current year FY 1975 show that the cost per claim for the Division of Direct Reimbursement was $4.11 as compared with $5.46 for the commercial insurance companies and $4.64 for the Blue Cross plans.

In conclusion, Mr. Chairman, let me say that we very much appreciate the initiatives you have taken in moving forward with these hearings and in seeking reasonable solutions to the problem of Congressional committee jurisdiction on the issue of national health insurance.

We appreciate the hard work you have undertaken and the personal commitment you have made to achieving a national health insurance plan which will benefit every American.

We urge you in the course of these hearings to hear from the people in their own surroundings and not only in Washington. We urge you also to visit Canada and to learn for yourselves what they have found to be good features and less desirable features of their national health insurance program. We should benefit from the Canadian experience.

Mr. Chairman, we thank you for the opportunity to present our views and are ready to answer questions about our testimony.

Mr. ROSTENKOWSKI. Thank you, Mr. Woodcock.

In your testimony you state that a sound national health insurance plan would preserve the best in our present health care system and replace its worst features. Could you give us more precise ideas of what you think are the best features of our present system that ought to be preserved?

Mr. WOODCOCK. Well, obviously, there are many, many things in the present system that under an efficient competitive system that came into being would continue to exist simply because they work better. We do not have the view, not the apocalyptic view that we will wipe out everything that is and start from scratch. We will start with what is and through an evolutionary system, which will be based on more efficient ways of delivery, with increasing emphasis on preventive care through an evolutionary process, take the system to where it would be compassionate and efficient and competitive.

Mr. ROSTENKOWSKI. Are you of the opinion, Mr. Woodcock, that this Congress is ready to adopt the entire package of the Health Security Act?

Mr. WOODCOCK. Well, in the statement we have tried to put emphasis on the principles which underly H.R. 21, and we are certainly not set in cement on every last detail of what we are proposing.

Mr. ROSTENKOWSKI. You called attention to problems such as unnecessary surgery, adverse drug reactions, and inaccurate X-rays. How would the health security proposal correct these problems, Mr. Woodcock?

Mr. WOODCOCK. Well, by encouraging those systems which presently have a much more effective performance in those areas. You take group cooperative systems, the better ones, have a much lower rate of hospital utilization and utilization of surgery techniques than, for example, in Blue Cross and Blue Shield taken across the board.

So that by emphasis on that, and companion measures, this would begin to meet that problem.

And I would like to add that as the quote from George Bernard Shaw indicated, there is presently in much of our system an economic incentive to perform surgery and to put people into hospitals, because sometimes you can only get covered under your insurance program when you are in the hospital rather than being treated as an outpatient when you don't get covered. All those things are incentives to unnecessary cost expenditures.

Mr. ROSTENKOWSKI. Thank you; Mr. Duncan will inquire.

Mr. DUNCAN. Thank you, Mr. Chairman.

I would also like to welcome Mr. Woodcock to the committee. You have always been very helpful.

I read recently or heard that you had indicated that it would be impossible for the Congress to enact a national health insurance program during this Congress. Am I correct in that?

Mr. WOODCOCK. That may have arisen—I was recently in Japan and on my way back I was in Seattle and Portland and I had meetings with our groups there on national health insurance. I was asked questions about that and I said in this calendar year, in view of the fact that these hearings are starting on the 5th of November and looking at the rest of the calendar, it is too much to expect that a bill can get through the House this calendar year.

We fervently hope that early in the calendar year of 1976 and in this session of the Congress, yes, there will be a bill come out of the House and then the Senate.

Mr. DUNCAN. Do you not agree that it would be best to start with something and build from that? I know for demagoguery and other purposes, if you call it that, politicians have talked about national health insurance since I have been with Congress for about 11 years, but we haven't moved in any direction. Don't you think it is best that we should start with something and build from that instead of taking a comprehensive program which would take years to implement?

Mr. WOODCOCK. We have given serious study to what we call incrementalism and that's the path we have been going down and not only have we not ameliorated the problem, the problem has grown progressively worse and we don't believe that is the answer.

Mr. DUNCAN. Mr. Wilbur Cohen, architect of the medicaid and medicare program testified before the committee recently. He said we should not move with haste, that we should take is slow because they had made so many mistakes in medicare and medicaid.

Mr. WOODCOCK. We underestimated the cost of medicare to begin with because the legislation specifically provided there was to be no interference with the system. Unfortunately, when you pour more dollars into an inefficient system you escalate the inflationary impact through the total system.

Mr. DUNCAN. But you say it was a system, a model of efficiency. Apparently it was not a model of efficiency.

Mr. WOODCOCK. The Social Security system with respect to retirement and disability costs, sir.

Mr. DUNCAN. But regardless of what political party that the administration might be at the time, HEW will always be administered by the political bosses. It has always been that way.

Mr. WOODCOCK. Well, it is to be taken for granted that the possibility of recovery is always present as long as we are dealing with human beings.

Mr. DUNCAN. Isn't it a fact that if the program is run by the Government, it is going to end up in a snafu anyway?

Mr. WOODCOCK. No, sir.

Mr. Duncan. That is what we have always found.

Mr. Woodcock. The record of the Social Security Administration over the years has been an excellent one. Their administrative costs compared to the private sector are exemplary.

Mr. Duncan. Do you think it can be done better than being run by—well, private industry to administer the program?

Mr. Woodcock. I most certainly do because when one looks at individual policies the private insurance industry keeps 50 cents out of each dollar which they collect. Half of what a person is paying for illness protection disappears at the moment of payment.

Mr. Duncan. Of course, it has been said if you transferred all the overhead that the HEW is not paying that the costs would be greater? What's your views on that?

Mr. Woodcock. We now have 1,800 separate providers in the private sector each with its own bureaucracy and I do not accept the fact that when management is in Government it is automatically bureaucracy but when management is in the private sector it is sacrosanct management. If we use the same terms they are both bureaucracies, there are 1,800 in the private sector that would be replaced by 1. That fact alone can say that the costs will be substantially reduced.

Mr. Duncan. Let's suppose that all we could get an opportunity to vote on, was the Long-Ribicoff approach to catastrophic illness. If that is all we had, would you oppose that?

Mr. Woodcock. Yes, sir. It would make the inflationary factors worse, it would benefit a very minuscule percentage of the American people and those who do not really need that kind of help. It would make the burden for the overwhelming majority of the American people worse than it is today.

Mr. Duncan. I don't follow you on that one because the middle income people are certainly, according to all the polls, certainly are favorable to some type catastrophic coverage.

Mr. Woodcock. The answers you get in polls depend upon the questions you are asked. If anybody was asked, would you like to be protected against the ravages of catastrophic illness, the answer is automatically yes. If you are asked, are you prepared to spend $11,500 before you begin to get protection of this proposed coverage the answer would be a great deal different.

Mr. Duncan. Thank you, Mr. Woodcock. Thank you, Mr. Chairman.

Mr. Rostenkowski. Mr. Corman will inquire.

Mr. Corman. Thank you, Mr. Chairman.

I appreciate your testimony this morning, Mr. Woodcock.

Looking at some of the absolutely essential features that we ought to put into a bill and recognizing that no bill is going to come out of this committee precisely as it was introduced by any of us, would you agree that first of all predicating it on a public system as distinguished from a private compulsory system, is one of those ingredients; effective cost controls is another; and a rejection of the economic needs test is a third. Those three things we ought to try to get in whatever we do.

Mr. Woodcock. We agree with that, yes, sir.

Mr. Corman. Are there any others that you can see that would be essential? I guess we both agree on universality. Maybe we have to wait for that. I think that incremental growth presents more problems than universality. But if we can get those three in whatever we do, and it does seem we are moving down the right road——

Mr. Woodcock. I would add to that that the universality and comprehensiveness of the system, and I would asume under the heading of cost controls there would be provisions through an evolutionary process for reforms to make the system more efficient. Otherwise, the cost controls would not come about.

Mr. Corman. Thank you very much.

Mr. Rostenkowski. Mr. Waggonner will inquire.

Mr. Waggonner. Thank you, Mr. Chairman.

Mr. Woodcock, you talk about the need to provide universal coverage under one system. That entails, I would suppose, a melding into a new universal system the existing medicare program?

Mr. Woodcock. Yes, sir.

Mr. Waggonner. And medicaid?

Mr. Woodcock. Yes, sir.

Mr. Waggonner. You talk about providing payment in full for all costs of those services which are covered. You don't envision anything in the way of a deductible?

Mr. Woodcock. No, sir.

Mr. Waggonner. With regard to financing, you propose financing through a trust fund based on payroll taxes and general revenues. Can you give me some idea of how much of this financing burden should be borne by payroll taxes broken down between the employer and the employee and how much should be involved or financed through the public sector with Treasury appropriations?

Mr. Woodcock. In the specific numbers that are in H.R. 21 at the present time it is estimated to be approximately 50 percent from the payroll taxes upon the employee and employer and 50 percent from the general revenues.

Mr. Waggonner. Can you tell me what you estimate realistically the cost to the Treasury would be, and what the payroll deductions to the employee and the employer would be?

Mr. Woodcock. With your permission, I would like to ask Dr. Falk to respond to that; since I rely on him for the numbers he may as well respond directly.

Mr. Waggonner. Yes, sir.

Dr. Falk. We have prepared a memorandum, Mr. Congressman, summarizing the financing picture as embodied in H.R. 21, including a presentation of the figures as if the billl had been effective before now, and applicable to prior years, to the current year and to prospective years taking into account the evidences that are available on the escalations that have been occurring, that are occurring, and that seem to be in the prospective picture.

[The information follows:]

Costs and Their Financing for the Health Security Program H.R. 21

(By I. S. Falk, Professor Emeritus of Public Health, Yale University School of Medicine; Member of the Executive Committee, Health Security Action Council; and Chairman of the Technical Subcommittee, Committee for National Health Insurance)

Mr. Chairman and members of the subcommittee, I appreciate having this opportunity to supplement Mr. Woodcock's testimony specifically with respect to costs and their financing for the Health Security Program. At the outset I would like to make three points.

First, I would reiterate what Mr. Woodcock has already said about inaccurate and misleading statements that have been made about the probable costs of the Health Security Program. It has been alleged, variously, that the Program would cost $57 billion, $77 billion, $100 billion, etc. And such figures have been presented as though to imply that these would be new and additional costs. The fact, as I will indicate, is that national expenditures for health and medical care would be much the same initially when the program is enacted as they would be if it is not. What would happen under the Program is a re-channeling of expenditures—more through the public sector and less through the private sector. In future years, however, the total national expenditures would be less with the Health Security Program than without it because of the built-in cost-containment provisions. Incidentally, for the tooling-up operations, the Program calls for only $200 million from Federal general revenues for its first year and for $400 million for its second year, and these would surely be fiscally manageable in the first years after enactment, a matter of considerable concern at the present time.

Second, I would emphasize—what everybody knows—that the Nation's actual expenditures for health care have long been escalating at a much steeper rate than the economy generally. In the fiscal year ended June 30, 1975, these expenditures, double what they were only six years before, reached about $117 billion and for the first time exceeded 8 percent or very nearly one-twelfth of our GNP. Moreover, the end of that climb is not in sight unless something of adequate scope is done about it. On the contrary, double-digit escalation continues for these expenditures; and if adequate steps are not taken to contain them, there will be no end to the steep escalation because there is no natural ceiling on what can be spent for health and medical care and because the forces for continuing steep escalation are inherent within the present medical-care system. If intervention and containment is more expensive now than it would have been if done sooner, and it would be expensive now, it will be more expensive later if further delayed.

My third point—with some redundancy—is to ask that, as you look at the costs for the Health Security Program, please be mindful that we are dealing with expenditures which in aggregate amount we as a Nation are already making, and that we are examining ways of making those expenditures more effective and more productive. We are not dealing primarily with new expenditures, new money or new demands on the national income or new additions to the GNP. On the contrary, the Health Security Program is the only proposal before you that has built-in cost-containment provisions. We are presenting a design not only for making comprehensive care of good quality available to everybody but also a system improvement proposal that has the promise of reducing what as a Nation we would otherwise be spending in the future.

In my Table 1, Part I shows national health expenditures. In fiscal year 1974, they were $104.2 billion—the first year in which they passed the $100 billion mark. Preliminary data indicate that in fiscal year 1975 they escalated by at least 12 percent and were probably about $117 billion. With indications of continuing escalation by at least 11 percent in the current fiscal year, they will be nearly $130 billion in the current fiscal year (to June 30, 1976). Assuming continuation of escalation at the annual 11 percent rate, this figure would equal $177 billion in fiscal year 1979 and would be moving toward $200 billion for fiscal year 1980.

TABLE 1.—*Estimates of national health expenditures*[1] *fiscal years 1974–79*

	Billions
I. National health expenditures, total:	
Fiscal year:	
1973–75 (actual)[2]	$104.2
1974–75 (estimated)[3]	116.7
1975–76 (estimated)[4]	129.5
1978–79 (estimated)[3]	177.2
II. Personal health care expenditures:[5]	
Fiscal year:	
1973–74 (actual)[2]	93.9
1974–75 (estimated)	105.1
1975–76 (estimated)[4]	116.7
1978–79	159.7

[1] All figures applicable to periods after fiscal year 1973–74 are subject to adjustments as may be required by changes in the rate of escalation of prices and costs.

[2] From N. Worthington, "Social Security Bulletin," February 1975, tables 1, 2, and 6.

[3] Estimated annual rate of increase: Plus 12 percent for fiscal year 1975–76; and plus 11 percent for each succeeding year.

[4] Only to June 30, 1976.

[5] Differ from SSA data by inclusion of expenses for prepayment and administration. Amounts equal 90 percent of total national health expenditures.

Since we are dealing primarily with the personal health service components of the total national health expenditures, part II of table 1 shows the expenditures for these items which constitute about 90 percent of the total: About $94 billion (actual) in fiscal year 1974; and estimated to have gone to $105 billion in fiscal year 1975, and to go to nearly $117 billion in fiscal year 1976 (to June 30th only). If the recent and current trends continue, the figure will be about $160 billion for fiscal year 1979 by which year the Health Security Program could be operational.

The Health Security Program proposes to embrace initially not all the personal health service expenditures, only about two-thirds—though increasing proportions in succeeding years. In table 2 you will see that our original estimates for the Program, presented in detail in the 1971 Hearings of the Committee on National Health Insurance Proposals (October 28, 1971, Part 3, pp. 524–586), showed expected expenditures of $56.7 billion if the Program were first effective in fiscal year 1974 and $62.5 billion if in fiscal year 1975. I have now developed revised estimates leading to the higher initial-year figure of $76 billion for fiscal year 1976 and to $108.6 billion for fiscal year 1979—assuming continual annual escalation of 11 percent as the average for all constituent expenditures items.

TABLE 2.—*Initial expenditures and financing under the health security program (H.R. 21, S. 3)*

	Billions
I. a. Original estimates:	
If first effective in:	
Fiscal year 1974	$56.7
Fiscal year 1975	62.5
b. First revised estimate:	
If first effective in: Fiscal year 1976	76.0
c. Current revised estimate:	
If first effective in: Fiscal year 1979	108.6
II. Sources of funds for the program, fiscal year 1979	
50 percent from health security taxes	54.3
From employers (75 percent)	40.7
From individuals (25 percent)	13.6
50 percent from Federal general revenues	54.3
Offsets from commitments (estimated):	
Medicaid	9.0
Insurance tax exemptions (individual)	6.0
Other health programs (including medicare, part B)	6.0
Offsets, subtotal	21.0
Net new outlays from general revenues	[1] 33.3

[1] Exclusive of relief to State and local governments of $5–$7 billion.

In Part II of Table 2, I have put together the best estimates I could for the financing of the Program in the future year FY 1979, adhering to the specifications in H.R. 21 and S. 3. To meet the expected initial year cost of $108.6 billion, 50 percent, $54.3 billion, would be derived from the Health Security taxes earmarked to flow into the Program's Trust Fund, and an equal amount would flow into the Fund from Federal general revenues. However, since the Program would take over a large part of Medicaid, all of Medicare and much or all of various other programs financed from general revenues, I have estimated that about $21 billion would be offsets, so that the net new outlay from Federal general revenues would be about $33 billion. About $5–$7 billion of that amount would be serving to provide fiscal relief to State and local governments.

As pointed out in our previous reports, the Health Security program, as presented in the bill, would incorporate (and broaden) Medicare and would repeal the taxes for that program—as well as absorbing most of the Federal and State tax-supported expenditures of Medicaid and of various other health, hospital and medical programs, thus relieving employers, individuals and governments of substantial expenditures for committed programs.

The changes which have been occurring in the last two or three years in the economy and in legislative proposals and public discussions have led us to reexamine the proposed financing of the Health Security Program and to consider various modifications. Since these have not yet had formal approval in our committees, they are tentative but deserving of study by your committee.

For example: Since H.R. 21 takes over the benefit provisions of Medicare and their costs, the Medicare taxes which would be repealed under the bill could be preserved (though perhaps with adjustment to eliminate the individual premiums required for Part B), with the yields of those taxes flowing into the Program's Trust Fund. The ceiling on the Medicare taxes on individuals should be raised to $21,000 (whether or not also imposed on employers' payrolls). As a result employers would be paying in the aggregate about 4½ percent instead of 3½ percent on their payrolls; wage and salary, self-employment, and non-earned income, each, would be subject to about 1 percent more than had been previously proposed and the requirement for sharing from Federal general revenues would be greatly reduced from the $33 billion shown in Table 2. Such a retention of the Medicare taxes is equitable since the Health Security Program would be providing comprehensive services and throughout an individual's life-time and not merely more limited services after reaching old age or becoming disabled.

The revised picture is shown in Table 3 which, for greater reliability of the data, uses the current FY 1976 as though it were the initial operating year for the enacted Program. In this table you will see that toward the expected total program cost of $76 billion, the combination of the specific Health Security taxes and the retention of the Medicare taxes would provide about $53 billion. Offsets from committed Federal general revenues would amount to somewhat more that $11 billion. Consequently, the net new outlays needed from Federal general revenues—to bring the total to $76 billion—would be $11.8 billion, about 15.5 percent of the total. And this reduced figure would also be exclusive of relief to State and local governments estimated to be in the range of $5–7 billion for health service obligations.

TABLE 3.—*Revised initial expenditures and financing under the Health Security program assuming initial year fiscal year 1975–76* [1]

	Billions
I. Revised estimate of program expenditures as for initial operating year in fiscal year 1975–76	[2] $70.0
II. Revised estimate of financing:	
a. Health Security taxes as in H.R. 21, S. 3	38.0
b. Retention of medicare taxes to $21,000 ceiling	[3] 15.0
Tax income, subtotal	53.0
c. Offsets from committed Federal general revenues: [4]	
1. Medicaid	6.0
2. Reduction of insurance tax (individual) exemptions	6.0
3. Other health programs including medicare, part B	4.0
Offsets, subtotal	11.2
d. Net new outlays from Federal general revenues	[5] 11.8

[1] Only to June 30, 1976.
[2] See table 2.
[3] Tentative possible revision in H.R. 21, S. 3.
[4] Estimates based on miscellaneous sources.
[5] Exclusive of relief to State and local governments of $5–$7 billion.

As with this illustration, so with various other approaches that could be explored toward arriving at equitable and adequate financing of the Program, without sacrificing goals or principles.

In view of the escalations which are occurring now in medical care costs (at an annual rate which will probably prove to be within the range 10–15 percent), it is obvious from the estimates in Table 3 for FY 1976 what the costs will be by the time such a Program could be enacted and become initially operational two, three or four years hence. We have done the arithmetic but the figures are only as reliable as the estimates about the escalations that will be occurring in those intervening years. From all indications, the costs of the Health Security Program will be higher than our estimates for the current fiscal year, but so will the national personal health care expenditures if we do not have this or a corresponding program enacted and operational. In other words, if enactment of the Health Security Program continues to be delayed, the national expenditures will be rising and the Health Security Program, when it is enacted, will need to incur much larger annual costs to rescue the Nation's health services from the steadily worsening crisis of health and medical costs. The longer delayed, the more heroic the measures that will have to be instituted.

I would like to close by referring again to the containment of cost escalations beyond a first operational year. I would emphasize the special advantage of the Health Security Program over alternative proposals by reason of its built-in provisions for control of costs. Through supports for systems improvements, prospective budgeting of the costs of each category of service, and through synchronization of the Program's budgeted costs with the trends in the general economy, the Health Security Program would within a few years bring national health care expenditures into line with the trends and the capacity of the national economy.

I urge special consideration of this point on the Committee. There are alternative proposals for which it is alleged that the costs would be less than for the Health Security program. What is not being presented, however, is that if their costs would be less it is because the total expenditure picture is not being shown, and because the emphasis is on an initial year proposal cost and not on prospective total costs to the Nation. The special virtue of the Health Security Program is that its built-in provisions are designed not only for meeting reasonable costs initially but also for containment of future cost escalations which are so threatening.

Thank you, Mr. Chairman.

Dr. FALK. Keeping the proportions of the financing as they are in H.R. 21, we have laid out the picture of what is ahead and a memorandum on this, as I understand, if not already available to the committee, will be. We have also pointed out that in light of the changing scene since the specifications were embodied in H.R. 21, that we have been exploring alternative ways of distributing the prospective costs of the health security program. We have taken into account especially that the health security program would take over all of the costs of the medicare program by embodying the present medicare benefits and broadening them and by taking over a very large proportion of medicaid and various other personal health service programs that are presently funded by the Federal Government, by Federal and State funds, by State and local funds, and in the private sector.

In view of that comprehensiveness of the specifications of the bill, we have been reexploring the financing picture in light of the changed scene in the economy. With one major change, we point out that the amount that would need to be derived from the Federal general revenues would be greatly reduced if the medicare taxes presently on the books were not repealed but were retained. Because in H.R. 21 there is a repeal of those taxes.

Since the H.R. 21 benefits would extend to all persons in the country, uniformly, including those who presently are eligible or in the future would become eligible under medicare program, but would be eligible for all of the benefits of the health security programs throughout their lifetime and not merely after they reach old age or become disabled that it would be equitable for the medicare taxes presently on the books to be retained.

Accordingly, to cite one set of figures, if we used the current fiscal year as an example, and using the current year because the data are a good deal more reliable than anything we can estimate for future years, we have said that if you assume for example that the health security program were in effect in its first operational year this year, the net draft on the Federal general revenues would be half of the expected costs of the program and which would be about $76 billion for the total program and about half of this, less some offsets that are presently being expended from general revenues, would leave the general revenue costs of about $33 billion.

However, if the medicare tax proposal were changed and were retained, that would reduce, according to the best available calculations I could carry out, to something under $12 billion. Now, as with that example, so with others. In the committee we have examined many other possible ways, redesigning the financing provisions, in order to effect improvements, in order to make the financing more nearly equitable, but without doing any damage to the fundamental goals or the principles of the health security program.

Mr. Woodcock. The memo to which Dr. Falk has reference is appendix C——

Mr. Fine. No; it is a separate one.

Mr. Woodcock. Oh, it is a separate one.

Mr. Waggonner. Do you envision anything in the way of automatic contributions escalator as far as payroll tax deductions are concerned which would mandate increases when you had escalated costs for either the employee or the employer? Or would this require some action on the part of the Congress?

Dr. Falk. Instead of escalating, if necessary, by changing the tax rates, the bill undertakes to effect the same result by effecting changes in the ceilings of the earnings or income amounts which would be subject to the taxes.

So then on the income side for the system there would be an automatic adjustment up to an appreciable degree. On the expenditure side there are provisions for cost controls by relating the amounts that would be available for distribution and expenditure to the amounts that are yielded on the income side.

Mr. Waggonner. And you don't propose changing the tax rate, you propose escalating the tax base to which you apply that rate?

Dr. Falk. Essentially so.

Mr. Waggonner. Do you envision a ceiling on that tax base?

Dr. Falk. Yes.

Mr. Waggonner. What is that figure?

Dr. Falk. For the current year we are using the figure of $21,000 but no ceiling on the employer payrolls.

Mr. Waggonner. Thank you.

Dr. Falk. That is the ceiling on the individual earnings.

Mr. Rostenkowski. Mr. Crane will inquire.

Mr. Crane. Thank you, Mr. Chairman.

Let me congratulate you, Mr. Woodcock, as a capable and skillful advocate of a case that I am not in sympathy with as you are doubtless aware, but I think you make a very effective presentation.

Let me ask you a question with respect to your statement that the system produces too few doctors; too few doctors in relation to what?

Mr. Woodcock. Excuse me, what, sir?

Mr. Crane. Too few doctors in relation to what?

Mr. Woodcock. Particularly in the area of family practice. We think now that the profession is developing a specialty which is essentially the old family practitioner, that is a good step in the right direction. But our heavy dependence upon imported doctors, I think, is a graphic illustration of the fact that we do in effect have a shortage.

Mr. Crane. Well, a shortage, you mean based upon some ideal ratio of doctors to patients? Or a shortage in contrast to other countries' doctor/patient ratios?

Mr. Woodcock. We have a bad maldistribution in certain specialties and we probably have an overabundance, if you take certain areas of the country, particularly with regard to general practice. We have a shortage in terms of the relationship to need.

Mr. Crane. Well, the reason I was curious about that is we have been increasing the number of doctors vis-a-vis patients in this country over the past decade and that ratio has been 3 to 1. We have been producing doctors at a rate three times faster than our population has grown.

The projections for the next decade remain the same. The current issue of U.S. News & World Report shows that the number of medical students this year is up 48 percent. We are importing, of course, too.

But I am wondering what a government—a comprehensive government program would do to improve this problem in light of the British experience which is suffering an enormous "brain drain?" They are losing about a third of their graduates out of medical schools annually now who are seeking greener pastures elsewhere. They are making up that deficiency by the importation of Pakistanis and Indians. What would we do differently here that would prevent a similar situation?

Mr. Woodcock. I would ask Mr. Glasser to help me with this answer.

Mr. Glasser. Yes. In relation to the shortage of physicians, the ratio of family practitioners to general population has decreased in the last 20 years.

The primary reason for that has been the increasing number of physicians going into specializations as you know.

It has also been a problem in that the maldistribution of physicians has exacerbated in the last 10 to 15 years, as you know, the ratio of physicians to population in the intercities and in rural areas is less now than it was 10 to 15 years ago.

The third aspect of that is as you know the number of physicians of foreign origin or foreign education excluding Canada, who came into the United States last year equaled the number we turned out from U.S. medical schools.

So that there is very real evidence that while the number of MD's has in fact increased, the shortages have increased with them. Now in relation——

Mr. Crane. Let me interrupt for just one point because I am not sure I get your point. There are only two countries that have a better doctor-patient ration in the world than the United States. We have been dramatically closing the gap in our doctor-patient ratio and when you talk about areas of specialization I gather you are not talking in quantatative terms but rather the absence of physicians in certain areas of specialization.

If that is the indictment, what would you propose as a positive Government act to remedy that?

Are you going to dictate, as Congress recently did, where doctors will practice?

Mr. Glasser. Let me first indicate in your generalization about my summary, that we have a shortage of the right kinds of doctors in the right places. That is where the shortages are, the wrong kinds of doctors.

Mr. CRANE. That is what I want to clarify.

Mr. GLASSER. So it is a numbers shortage and speciality shortage. It is of no value to the residents of the inner city of Harlem that there may be 20 open-heart surgeons practicing in the area. I am making up the number. I do not know what it is.

They would not be seen for the ills and ailments of their kids.

Now, in terms of what can be done about this, the health security bill though in fact not going the incremental route but through seeing the program as a whole, through its resources developments which provides for an overall tax on the system for development of services and programs in areas where there are needed, would provide resources for the building of facilities, for the encouragement of physicians and other types of specialists to go into the shortage areas——

Mr. CRANE. How would you encourage them?

Mr. GLASSER. We would encourage them—or the Government would encourage them through the health security fund, one, by making available decent resources so there are decent places for them to practice in relation to other members of the health team.

Mr. CRANE. This is the way to clear up the problem of the inner city, you mean?

Mr. GLASSER. No, sir, I am talking about specifically making available health centers and making available funds to staff those health centers where there are shortages.

Second, it would encourage the development o fthe HMO type of organization, not only through the making available of funds for the organization but actually for payment for services which we do not at this point in this country. So that the patients would have the funds to pay for the services, or have their services paid for, in the inner cities and rural areas because there is evidence that if the funds are available to buy those services, people will practice in those areas and the team approach can be used.

Under the present system we continue to turn out more and more specialists who rush in a great hurry to the suburbs and to Los Angeles, New York, Boston, et cetera, leaving the present situation to get worse.

Mr. CRANE. My time has expired. I would suggest that you look at that Hillsdale College study on the whole issue of maldistribution of physicians, because it is the only comprehensive study that has been made and it deals with both the geographic problem and the specialty problem.

I agree that we have problems, but, as I think, Dr. Davis observed, they have in virtually every other country and I am not as confident as I think you are that the Government has the answer to that one.

Mr. GLASSER. I would like to simply say that there are very substantial numbers of other very comprehensive studies that come to a quite different conclusion.

Mr. CRANE. Would you provide those for me, please?

Mr. GLASSER. Yes, sir.

Mr. CRANE. Thank you.

[The following material was subsequently supplied for the record:]

Department of Health, Education, and Welfare,
Public Health Service,
Health Resources Administration,
Rockville, Md., November 20, 1975.

Mr. Max Fine,
Committee for National Health Insurance,
Washington, D.C.

Dear Max: In response to your recent request for information on published studies dealing with maldistribution of medical specialty manpower nationally and in selected geographic areas, I contacted a few analysts in the Bureau of Health Manpower who are especially knowledgeable in this subject.

In their opinion 19 references I have checked in the enclosed annotated bibliography entitled "Medical Specailties" are excellent for your purpose.

If I can assist you again, let me know.

Sincerely,

Alexander Adler,
Special Assistant for Extramural Affairs.

Enclosure.

Medical Specialties

ANNOTATED BIBLIOGRAPHY AND SELECTED ONGOING STUDIES

In recent years, a considerable amount of attention in the literature of health manpower has focused upon supply and requirements profiles of medical specialty resources. Specifically, interest has frequently tended to centralize on questions of the distribution of specialists and of the increasing use of paramedical personnel by health professionals. Given the wealth of information on this subject and the fact that little of the material has been systematically compiled, a need arises to summarize many of the major activities being undertaken.

This report, consequently, provides an annotated bibliography of a number of recent publications on manpower studies in the major medical specialties, as well as a listing of selected ongoing studies of the same type. For publications and studies, items are grouped along lines of the same broad categorization of medical specialties as utilized by the American Medical Association—general practice. medical specialties, surgical specialties, and other specialties. It should be noted that research activities in a number of the smaller specialities are not included in this report, partly for brevity's sake and partly because few studies have been undertaken or published in these specialties.

The material presented here represents a selective, not an exhaustive listing. In general, the subjects discussed in the publications and studies presented in this report cover supply and requirements of specialists, task delegation, the use of allied health personnel, practice characteristics, and opinion surveys. Health manpower planners and analysts alike should find this material useful for evaluating the status of medical specialty manpower nationally and for selected geographic areas. Comparisons of the information presented, however, should be undertaken cautiously considering the conceptual and methodological variations between the various articles and studies.

This report was prepared by the Manpower Resources and Requirements Branch of the Division of Manpower Intelligence, BHRD, HRA.

PART I—ANNOTATED BIBLIOGRAPHY

Overview

1. Clawson, D. K., "Planning Residency Programs Based on Physician Projections," in publication. Description of one approach for the Washington, Montana, Alaska and Idaho Area to correct physician specialty maldistribution, by basing the number of residency training slots on adjusted Health Maintenance Organization physician specialty distribution ratios.

2. Committee of Public Health, "Report of the Committee on Public Health," *Bulletin N.Y. Academy of Medicine*, Vol. 44, pages 1079–1084, August, 1968. Good summary of types of specialists and forces contributing to growth of specialism at the expense of general practice. Recommendations are made as to methods to remedy the maldistribution problem.

3. Elwood, P., *Medical Manpower Specialty Distribution Projections, 1975* and *1980*, Institute of Interdisciplinary Studies, Minnesota, 1971. Contains specialty projections based on the current supply of physicians; projections not disaggregated by country of graduation.

√4. Knowles, J. H., "Quality and Quantity of Medical Manpower," *J. Med. Educ.*, Vol. 44, pages 81–118, February, 1969. A review of current efforts to do medical

manpower studies. A very good summary of the problems of specialization, as well as a review of individual specialties and their particular manpower problems.

√5. Mason, H. R., "Manpower Needs by Specialty," *J.A.M.A.*, Vol. 219, pages 1621–1626, March, 1972. A discussion of the physician specialty maldistribution problems with charts containing individual specialty/population ratios for the states and ratios prevailing among various health maintenance organizations.

6. National Center for Health Statistics, *Characteristics of Patients of Selected Types of Medical Specialists and Practitioners*. NCHS Publication Series No. 10, No. 28, July, 1963–June, 1964. Data from the National Health Survey on patient visits to specialists, distributed by demographic characteristics of patients.

7. Peterson, P. Q., and Pennell, M. Y., *Health Manpower Sourcebook 14, Medical Specialists*, USDHEW, 1962. Good historical data on medical specialty trends.

8. Scheffler, R. M. "Regional Distribution of Physicians and Specialists," *Review of Regional Studies*, Vol. 11, pages 63–80, Winter, 1972. An analysis of the geographic specialty maldistribution problem, including charts of divisional specialty population ratios.

9. Stevens, R., "Trend in Medical Specialization in the U.S.," *Inquiry*, Vol. VIII, pages 9–19, September, 1970. An excellent article that contains a discussion of the causes of specialization and methods that could be utilized to prevent further maldistribution.

General Practice and Family Practice

1. Bishop, F. M., et al., "The Family Physician—Ideal and Real," *General Practice*, pages 169–177, 1969. After survey of 950 rural family physicians in Missouri, in 1968, comparison made between the real characteristics of the practice and the "medical ideal" of what it should be.

√2. Brown, J. W., et al., "A Study of General Practice in Massachusetts," *J.A.M.A.*, Vol. 216, pages 301–309, April, 1971. A study of 13,000 patient visits to 15 General Practitioners in Massachusetts with "non-sickness" being the most common diagnosis.

3. Committee of Education, American Academy of Family Practice, *Education for Family Practice*, November, 1969. Discussion of the content of Family Practice and how it relates to the education of specialists in this field.

4. Committee on Public Health, "Estimating the Need for Physicians, II General Practice," *Bulletin N.Y. Academy of Medicine*, Vol. 44, pages 1075–1079, August, 1968. Very good discussion of the need for primary care physicians and the reasons for their decline.

5. Crawford, R. L., "Reasons Physicians Leave Primary Practice," *J. Med. Educ.*, Vol. 46, pages 263–268, April, 1971. A discussion of the results of questionnaires sent to 73 physicians who had left primary care practice.

6. *Medical World News*, "How Big Is the Swing to Family Practice," pages 54–63, September, 1972. Discussion of the reasons and the magnitude of the new popularity of Family Practice, as well as inherent problems in the specialty which may make this popularity short-lived.

7. National Disease and Therapeutic Index, *Study of Patient Visits to the General Practitioner*, Ambler, Pa. April, 1964. Results of a national study done in 1962 of 1,500 General Practitioners, with a discussion of patient load and conditions diagnosed compared to the patient load and conditions diagnosed by other specialists.

8. Overpeck. M. D., "Physicians in Family Practice 1931–1967, "*Public Health Reports*, Vol. 85, pages 485–494, June, 1970. An excellent review of historical information of the practice characteristics of physicians in primary care. Contains good historical trend data on numbers of physicians.

9. Parrish, H. M., "Time Study of General Practitioners' Office Hours," *Arch. Environmental Health*, Vol. 14, pages 982–998, June, 1967. A time and task analysis of the practice of 25 General Practitioners in Missouri.

10. Riley, G. J., "A Study of Family Medicine in Upstate New York," *J.A.M.A.*, Vol. 208, pages 2307–2314, June, 1969. A survey of the practice characteristics of 103 General Practitioners in New York done in 1966.

√11. Schonfeld, H. K. et al, "Numbers of Physicians Required for Primary Medicale Care," *New England J. Med.*, Vol. 286, pages 571–576, March, 1972. An excellent article on requirement for primary care; estimates developed for the number of pediatricians and internists required, based on the judgment by physicians in these fields of what constitutes good primary care and the frequency of conditions requiring it. The estimates are disaggregated by the age and sex distribution of the population.

12. Stevens, R., 'Death of General Practice," *Medical Opinion*, pages 27–35, July, 1971. Very good discussion of the decline of General Practice and its relation to the growth of specialization.

13. Walsh, J. G., "New Specialty—Family Practice," *J.A.M.A.*, Vol. 212, pages 1191–1207, May, 1970. A good summary of the historical development of Family Practice and the hopes for the future of it.

14. White, K. L., "General Practice in the U.S.," *J. Med. Educ.*, Vol. 39, pages 333–343, April, 1964. A very good article on the reasons for the decline of General Practice, and the amonut of primary care being delivered by pediatricians and internists. Contains a task analysis of the conditions treated by all three types of physicians, as well as the frequency with which these conditions are treated.

15. Willard, W. R., "The Primary Physician," *J. Med. Educ.*, Vol. 44, pages 119–125, February, 1969. Description of the role of primary physicians in context of the changing society, and their relation to physician assistants.

Dermatology

√1. Fahs, I. J. and Lynch, F. W., "Dermatologists in the U.S.," *Arch Dermatology*, Vol. 105, pages 836–844, June, 1972. This manpower survey investigates the entry of dermatologists into the U.S. health care system, the extent and nature of their provision of care (patient contact) and the nature and rate of depletion of their manpower.

2. Joint Committee on Planning for Dermatology, *National Program for Dermatology*, May, 1969. In depth report of education, research, administration, funding and manpower in Dermatology.

Internal Medicine

1. Altman, I. et al, "The Office Practice of Internists, Patient Load II," *J.A.M.A.* Vol. 193, pages 667–672, August 1965. Contains data on weekly patient load and related elements in the practice of a sample group of internists in N.Y. State.

2. Clark, D. A. et al, "The Office Practice on Internists, Professional Activities Other Than Care of Private Patients," *J.A.M.A.*, Vol. 193 pages 177–181, October, 1965. Most of the activities described pertain to medical practice rather than to professional or community activities of a more general nature.

3. Kroeger, H. H., et al, "The Office Practice of Internists, Feasibility of Evaluating the Quality of Care, I," *J.A.M.A.*, Vol. 193, pages 371–376, August, 1965. Results of a survey of a 50 percent sample of N.Y. State Society of Internal Medicine membership, a demographic profile which is expanded in the other articles of the series.

4. Kroeger, H. H. et al, "The Office Practice of Internists, Background and Form of Practice of 500 Internists in New York State, V.," *J.A.M.A.*, Vol. 194, pages 145–150, November, 1965. Demographic characteristics of the sampled internists, as well as present type of practice engaged in, training background, kind and extent of subspecialty status.

5. Johnson, A. C., et al, "The Office Practice of Internists, Characteristics of Patients, III," *J.A.M.A.*, Vol. 193, pages 916–922, September, 1965. Descriptive data on about 9,000 patients seen in 1963. About one-half of the patients seeing subspecialists were referred.

6. National Disease and Therapeutic Index, *Patient Visit Trends in Internal Medicine*, Ambler, Pa. 1964. Based on a national survey of 1,500 internists; data on number of patient visits, causes for the visits to all physicians compared to those for internists in particular between 1960 and 1963.

7. National Disease and Therapeutic Index, *Study of Internal Medicine, Cardiology, and Gastroenterology*, Ambler, Pa. 1964. Data on these specialties based on 19,000 patient visits during the year of 1962; tables on daily patient load, age, and sex distribution, number of referred patients and diagnosis.

8. Owens, A., "Forecast for Internists: A G.P.'s Life," *Medical Economics*, pages 81–87, February, 1972. Discussion of the increase in earnings among internists as well as the increasing amount of their time being devoted to primary care and the effect of National Health Insurance on the internist's practice.

9. Riddick, F. A. et al, "Use of Allied Health Personnel in the Internists' Office." *Arch. Internal Med.*, Vol. 127, pages 924–931, May, 1971. Presents results of a 50 percent sample of the membership of the American Society of Internal Medicine in 1969. Good summary; appears to be an inverse relationship between the number and amount of tasks delegated and the physician/population ratio of the

area. There appears to be a considerable gap between what an internist believes he can delegate and that which he actually does delegate to allied health personnel.

10. The Arthritis Foundation, *Professional Manpower in Rheumatalogy*, January, 1973. Discussion of current manpower supply and training programs in the field, as well as the prevalence of the disease, and the development of future manpower requirements.

Pediatrics

1. Bergman, A. B., et al. "Task Identification in Pediatric Practice," *American J. Disabled Children*, Vol. 118, pages 459–467, September, 1969. The article advocates task delegation to remedy physician manpower shortage in Pediatrics.

2. Bergman A. B., et al, "Time Motion Study of Practicing Pediatricians," *Pediatrics*, Vol. 38, pages 254–263, August, 1966. After performing a time and task analysis of four pediatricians, the medical student observers found the pediatricians' services to be underutilized.

3. Burnett, R. D., "Pediatric Manpower Needs—Can They Be Met?" *Pediatric Clinics of North America*, Vol. 16, pages 781–790, November, 1969. According to this article there will be a need for 5,000 to 17,000 additional Pediatricians by 1980, along with an increase in the productivity of presently practicing Pediatricians.

4. Hessel, S. J. and Haggerty, R. J., "General Pediatrics, a Study of the Practice in the Mid 1960's," *J. of Pediatrics*, Vol. 73, pages 271–279, August, 1968. A survey of the characteristics of the office practice of about 20 private pediatricians in Monroe County, New York, in 1966.

5. Schiff, D., et al, "The Pediatric Nurse Practitioner in the Office of Pediatricians in Private Practice," *Pediatrics*, Vol. 44, pages 62–68, July, 1969. Describes the tasks delegated to pediatric nurse practitioners and the economic benefits thereof.

6. Yankauer, A. et al, "Survey of Allied Health Workers Utilization in Pediatric Practice in Massachusetts and in the U.S.," *Pediatrics*, Vol. 42, pages 733–742, November, 1968. Compilation of the results of a questionnaire survey of Massachusetts Pediatricians in 1967 which indicated that they favored the use of allied health workers; considerable variation occurred among the respondents as to which of their tasks they would delegate.

7. Yankauer, A., et al, "Physician Productivity in the Delivery of Ambulatory Care," *Medical Care*, Vol. VIII, pages 35–46, January February, 1970. The results of a 1970 survey (90 percent sample) of all board certified pediatricians reveal underutilization of both the medical and nursing staff.

8. Yankauer, A., et al "Task Performance and Task Delegation in Pediatric Office Practice," *Amer. J. of Public Health*, Vol. 59, pages 1104–1117, July, 1969. Another survey of pediatricians as to their interest in allied health workers and a task delegation survey performed in 1967 of all regular fellows in the American Academy of Pediatrics (88 percent response rate).

Surgery

1. Bunker, J. P., "Surgical Manpower—A Comparison of Operation and Surgeons in the U.S., and in England and Wales," *New England J. Med.*, Vol. 282, pages 135–144, June, 1970. Discussion of the reasons that half as many surgeons in England perform twice as many operations as do U.S. surgeons and at the same time provide adequate care.

2. Bunker, J. P., "Surgical Priorities and the Quality of Medical Care," *Bulletin New York Academy of Med.*, Vol. 48, pages 173–177, January, 1972. Discussions of the variation in surgery for particular areas and populations, and the causes for these variations.

√3. Hughes, E. F. X. et al, "Surgical Workloads in a Community Practice," *Surgery*, Vol. 71, pages 315–327, March, 1972. An excellent article which attempts to measure the operation workload of a population of general surgeons in New York. The operations are described in terms of hernia equivalents and the results appear to substantiate the hypothesis that there are too many surgeons who consequently are underutilized.

4. Kisch, A. I., et. al., "An Epidemiologic Approach to the Study of the Incidence of Surgical Procedures," *Medical Care*, Vol. VII, pages 471–480, November, 1969. Using the incidence of three surgical procedures in a variety of hospital settings, an approach is outlined for studying the environment for surgical procedures by epidemiologic analysis.

5. McPhedran, N. T., and Ekstrand, E., "Study of Surgical Practice in Alberta for 1970," *In publication.* An attempt to use present user rates in Alberta, Canada, as a basis for future requirements for manpower in seven surgical specialties.

√6. Moore, F. M. et al., "The Production, Attrition and Biologic Life Time of Surgeons in Relation to the Population of the U.S., *Annals of Surgery,* Vol. 178, pages 457–468, October, 1972. Good manpower paper with considerable data on board certified surgeons. Gives projections based on board certified surgeons for all of the ten surgical specialties; authors one part of the study of surgical services in the U.S. (SOSSUS) team.

7. Owens, A., "Good-bye to the Generalist," *Medical Economics,* pages 125–133, March, 1972. The earning superiority of general surgeons is narrowing partially due to their oversupply, maldistribution and underemployment.

8. Robinson, G. W., "Non-Physician Surgical Assistants," *J. of the American Hospital Association,* Vol. 45, pages 76–83, June, 1971. Describes the reasons for the need for these assistants and their utilization; study based on a sample of five assistants.

9. Zuidema, G. D., "An Assessment of Issues Facing American Surgery," *Surgery,* Vol. 70, pages 493–497, October, 1971. A discussion of the issues facing American surgeons and their relationship to the SOSSUS effort.

10. Editorial, "Foreign Medical Graduates and Surgery in the U.S.", *Archives Surgery,* Vol. 102, pages 532–533, May, 1971. Discusses the increasing numbers of foreign medical graduates who come to the U.S. for surgical training and the resulting increase in numbers of those who chose to remain in this country. Gives suggestions on how to deal with the situation.

Neurosurgery

1. Bergland, R. M., "Neurosurgery May Die," *New England J. of Medicine,* Vol. 288, pages 1043–1046, May, 1973. A critique of current training of residents in neurosurgery, particularly of the facts that there are too many programs training too many neurosurgeons, and the inadequacy of the training that is given. One reason for these problems is the fact that the training is related more to the service needs of teaching institutions rather than to the eventual clinical needs of society.

2. Evans, J. P. and Rossin, A. D. "The Significance for Neurosurgery of a Recent Survey of Foreign Medical Graduates in Neurological Surgery and Pediatrics," *J. Neurology,* Vol. 30, pages 356–358, March, 1969. Results of a survey of 100 program directors of neurosurgery programs, with an 87 percent response rate. Of 126 FMG's who received 3 or more years of training in the U.S. between 1950 and 1965, 43 percent have maintained permanent residence in the U.S. Discussion of the reasons for this are also mentioned in the article.

Obstetrics and Gynecology

1. American College of Obstetricians and Gynecologists, *Conference on Obstetric and Gynecologic Health Personnel,* Summary of Proceedings, November, 1971. Discussion of the utilization of all types of personnel in obstetrics and gynecology.

2. Bishop, E. H. "The National Study of Maternal Care," *International Journal of Gynecology and Obstetrics,* Vol. 8, pages 745–751, September, 1970. Results of a 1968 questionnaire study of 5,500 hospitals. Discusses infant and maternal mortality rates relating them to hospital size and geographic region. Also discusses the relation of manpower involved to these rates and manpower involved in delivering obstetrical anesthesia.

3. Hellman, L. M., et al., "The Use of Health Manpower in Obstetric-Gynecologic Care in te U.S." *International J. of Gynecology and Obstetrics,* pages 732–738, September, 1970. Survey of a 25 percent sample of obstetricians in private practice across the Nation. This is a preliminary report of the results of this survey. Apparently, obstetricians supply about one half of the obstetric care to women, the remainder being provided by general practitioners. The response rate was 78 percent, and a generally favorable opinion was expressed towards maternity nurses.

4. Jeffers, W. N., "OBG Financially Healthy and Expectant," *Medical Economics,* pages 90–97, August 7, 1967. A discussion of the practice characteristics and fees charged by these specialists.

5. Owens, A., "OBG Specialists," *Medical Economics,* pages 128–131, August 17, 1970. The economic outlook for obstetricians and gynecologists remains optimistic.

However, mounting and changing demands for patient services may subject these specialists to unaccustomed pressures in the years ahead.

6. Owens, A., "Forecast for OBG Specialists, less OB, more G," *Medical Economics*, pages 183–191, April 10, 1972. A discussion of the new trends occurring in this specialty, notably a swing to more gynecology than obstetrics.

7. Peckham, B. M., "Optimal Maternal Care," *Obstetrics-Gynecology*, Vol. 33, pages 686–688, June, 1969. Provides a definition on what constitutes optimal maternal care.

8. Yankauer, A., et al., "Performance and Delegation of Patient Services by Physicians in Obstetrics and Gynecology," *American J. of Public Health*, Vol. 61, pages 1545–1555, August, 1971. Results of a mail survey to a 25 percent sample of obstetricians and gynecologists in the U.S. Details the various tasks delegated to registered nurses.

9. Yankauer, A., et al., "Obstetrics-Gynecologic Practice in the U.S.," American College for Obstetricians and Gynecologists, October, 1970. Results of a mail survey of a 25 percent sample of obstetricians and gynecologists. Discusses practice arrangements, workloads and other characteristics.

10. Yankauer, A., et al., "Physician Output, Productivity and Task Delegation in Obstetric-Gynecologic Practice in the U.S.," *Obstetrics and Gynecology*, Vol. 39, pages 151–160, January, 1972. Study of the variations in practice arrangements and task delegation among obstetricians.

Ophthalmology

1. Fahs, I. J., "Vision Manpower in the U.S.," *American J. of Public Health and the Nation's Health*, Vol. 60, pages 1760–1768, September, 1970. A numerical analysis of vision manpower in the U.S., including ophthalmologists and optometrists; also includes a discussion of growth trends.

2. National Center for Health Statistics, *Ophthalmology Manpower—A General Profile, U.S.*, 1968. USDHEW Publication No. (HSM) 73–1800, December, 1972. Presents statistics on selected demographic and professional characteristics of active and inactive ophthalmologists.

Orthopedic Surgery

1. American Academy of Orthopedic Surgeons, *A National Health Program for Orthopedics, A Preliminary Report, January*, 1969. Detailed description of all aspects of orthopedic practice.

2. American Academy of Orthopedic Surgeons, *Proceedings of a National Workshop on the Care of Orthopedic Patients—A Team Approach*, November, 1971. Discussion of manpower in orthopedics, task delegation, and determination of future manpower needs.

√3. Clawson, D. K. and Requa, R., *Orthopedic Manpower Study, Phase I*, University of Washington, Seattle, 1971. Results of a questionnaire survey of a 50 percent sample of orthopedists in 1970. A product of a Division of Manpower Intelligence, Bureau of Health Manpower Education contract.

√4. Clawson, D. K. and Requa, R., *Orthopedic Manpower Study, Phase II*, University of Washington, Seattle, 1972. Data obtained from direct observation of a sample of orthopedists in the Northwest, by medical student observers, in 1972 to validate Phase I of the study and to identify the conditions treated and time allocated. Another phase of the Division of Manpower Intelligence, Bureau of Health Manpower Education contract.

5. Hershey, J. H., "A New Health Professional—The Orthopedic Assistant," *The HSMHA Health Reports*, Vol. 86, pages 669–673, August, 1971. Discussion of the needs for and the duties of an orthopedic assistant.

Urology

1. Flocks, R. M., "American Urology—1969—Its Achievements—Its Challenges," *J. of Urology*, Vol. 102, pages 373–377, October, 1969. Good discussion of the growth of the practice and the manpower involved.

2. Lattimer, J. K., *Demographic Study on Urology*, American Urological Association, 1971. Preliminary data based on a national study of urologists. No analysis of the data is included.

3. Owens, A., "Urologists—Enjoying a Seller's Market," *Medical Economics*, pages 123–126, September, 1969. Discussion of the fees charged by urologists and their practice characteristics.

4. Statistical Committee of the American Urological Association. *American Urology*, 1970. Estimates of current and future capabilities to provide for the nation's urological needs. Incomplete copy, many figures incomplete.

Anesthesiology

1. Ament, R., *Revised Recommendations for the Anesthesia Care Team*, American Society of Anesthesiologists, July, 1971. Includes a demographic study of physician manpower in anesthesiology and proposes functions and distributions for them in the practice.

√2. Ament, R., "Dilivery of Anesthesia Care-Present and Future," *New York State J. of Med.*, Vol. 72, pages 2179–2188, September, 1972. An excellent article that includes a demographic profile of anesthesiologists, including their age and sex distribution. Projections for manpower in anesthesiology requirements are developed as well as for allied health personnel. Suggestions are made of methods to be utilized to alleviate the manpower shortages that exist in the specialty.

3. Caron, H. *Anehthesiological Manpower in the U.S. in 1970 Clinical Anesthesia Series*, Public Health Considerations in Anesthesiology and Acute Medicine, F. A. Davis, Philadelphia, September, 1971. Description of the various categories of personnel involved in the practice of anesthesiology.

4. Coe, R. M. and Wessen, A. E., *A Survey of Anesthesia Practice in the U.S.*, Washington University, St. Louis, 1967. Survey of conditions of contemporary anesthesia practice, attitudes and perceptions of personnel, career patterns, measures of quality of care and utilization of surgical facilities.

5. Eckenhoff, J. E., "Shortage of Anesthetists-Real or Artificial," *Amer. J. of Surgery*, Vol. 117, pages 607–609, May, 1969. Discussion of changes in surgical care procedures which would reduce so-called shortage of anesthetists.

√6. Gravenstein, J. S. et al, "Analysis of Manpower in Anesthesiology," *Anesthesiology*, Vol. 33, pages 350–357, September, 1970. Task analysis of the practice and the determination that many tasks can and should be delegated to relieve manpower shortages.

√7. Gravenstein, J. S., et al, *Analysis and Forecasting of Anesthesia Manpower in Cuyahoga County, Ohio*, Technical Memorandum No. 259, Case Western Reserve University, March, 1972. Uses supply and demand models as well as the Delphi technique to make manpower projections for anesthesia personnel.

8. Jenkins, M. T., "Anesthesiology-Some of its Problems and Responsibilities," *J.A.M.A.*, Vol. 211, pages 282–285, January, 1971. Good summary of the practice and its manpower problems.

9. National Institute of General Medical Sciences, *Research Training in Anesthesiology*, Report of the Anesthesia Training Grants, June, 1971. Good summary of manpower problems, factors influencing them, and the effects of the training grants.

√10. Reisman, A., et al, *Analysis and Codification of Present and Past Opererative Anesthesia, Anesthesia Related Tasks* ,Technical Memorandum No. 229, Case Western Reserve University, June, 1971. Uses a point method of job evaluation to analyse anesthesia tasks and assign them to various levels of personnel according to their complexity.

Neurology

1. Severinghaus, A. E., *Neurology—A Medical Discipline Takes Stock*, USDHEW Publication No. (NIH) 72–175, 1971. Study of manpower, research, financial support and the future of the specialty.

2. Severinghaus, A. E., "Neurology and Neurological Sciences Research and Training Study," *Arch. Neurology*, Vol. 17, pages 131–143, November, 1967. An indepth study of the personnel, administration, financial support, and teaching and research in the discipline. A summary statement of findings from 1963–1966.

Pathology

1. Greenbury, C. L., "Manpower in Pathology 1969–1975," *Journal of American Pathology*. Vol. 24, pages 551–563, September, 1971. An assessment of demand for consultant pathologists in Great Britain, as well as an assessment of the adequacy of the training of personnel.

2. Hotckiss, S. M., (ed.) *Survey of American Pathologists*, The Williams and Williams Co., Baltimore, pages 4–13, 1966. General description of the characteristics of U.S. pathologists.

3. National Institute of General Medical Sciences, *The Role of Research Training Grants in Academic Pathology*, A Report by the Pathology Training Committee, July, 1971. Good summary of academic pathology manpower needs.

4. Williams, M. J., "Women Physicians as a Source of Recruitment for Pathology," *Arch. Path.*, Vol. 88, pages 42–45, July, 1969. Discussion of manpower shortages and recruitment of women M.D.'s to partially alleviate the problem. The specialty is more popular among female than male M.D.'s.

Physical Medicine and Rehabilitation

1. Commission on Education in Physical Medicine, "Estimates for the Need of Physiatrists in the U.S.," *Bulletin No. 4*, 1966. A discussion of the need for these specialists, with specific numbers for physiatry, along with the problems associated with meeting these needs.

2. Commission on Education in Physical Medicine and Rehabilitation, "The Vocational Interests, Values, and Career Development of Specialists in Physical Medicine and Rehabilitation," *Bulletin No. 9*, 1968. Another report based on a 1966 survey of physiatrists, detailing demographic and training background.

√3. Commission on Rehabilitation Medicine, "Current and Projected Physiatrists Supply, Need, and Demand," *CRM Bulletin* 14, March, 1973. The most comprehensive study of this specialty and a good format for other specialty studies. Somewhat superficial due to lack of data.

4. Halbertsam, J. L. and Decso. M. M., "A Cross-Cultural Evaluation of Graduate Training in Physical Medicine and Rehabilitation by Foreign and U.S. Residents," *Arch. Physical Med. and Rehabilitation*, pages 621–631, September, 1966. A survey of 70 Foreign medical graduates and 50 U.S. medical school graduate residents as to their perceptions and evaluations of their respective training programs.

Psychiatry

1. American Psychiatric Association, Commission on Manpower, *The Crisis in Mental Health Manpower and How To Meet It*, March, 1966. A discussion of future manpower needs in this field for all categories of personnel, and the implications of these needs.

√2. National Institute of Mental Health, *The Nation's Psychiatrists*, Public Health Service Publication No. 1885, 1969. Excellent report which describes the findings of the first full-scale survey of the nation's supply of pspchiatrists based on a 1965 survey of professional and background characteristics of 18,740 physicians who practice psychiatry. Also discusses geographic distribution and utilization.

3. Nolfi, A. J., "A Brief Working Paper on NIMH Training Programs in the 1960s." Designed to increase the numbers of M.D.'s selecting the specialty of psychiatry. Prepared for the Division of Manpower Intelligence, BHME, DHEW, April, 1973. Excellent discussion of the effect of Federal money on one shortage specialty. Discusses the successes of Federal funding as well as the failures. Provides expert lessons on how there failures can be avoided in the future.

4. Pierce, G. M., "Manpower: The Need for Negro Psychiatrists," *J. N. M. A.*, Vol. 60, pages 30–33, January, 1968. Discussion of the great need to recruit Negro psychiatrists, and a description of the practice characteristics of Negro psychiatrists compared to those of other pyschiatrists.

5. Ramshone, M. T., "The Major Thrust in American Psychiatry: Past, Present, and Future," *Perspectives in Psychiatric Care*, Vol. IX, pages 144–155, November, 1971. A general review, with a section on mental health manpower and all the various types of manpower involved in psychiatric care.

6. Robin, A. A., "Distribution and Origins of Manpower and Workload in the Psychiatric Services," *Brit. Med. J.*, Vol. 3, pages 774–776, September, 1969. Discusses the developments in medical manpower in hospital services for adult psychiatry in a large metropolitan region of Great Britain. Includes relative rates of developments of manpower and workload from 1948–1968, nationally for psychiatric and general medical services.

7. Talkington, P. C., "Medicine and Psychiatry in the 70's: A Perspective," *The W .Va. Medical J.*, Vol. 67, pages 119–126, May 1971. An excellent general review, with a very good section of factors that are important in determining the requirements for manpower in psychiatry, as well as a discussion of the trends in the use of manpower in medicine and psychiatry in particular.

Radiology and Therapeutic Radiology

1. Abrams, H. L., "Observations on the Manpower Shortage in Radiology," *Radiology*, Vol. 96, pages 671–674, September, 1970. A discussion of the supply of manpower and the demand for radiological services, with the problem of possible overutilization of these services also included.

√2. Knowles, J. H.: "Radiology—A Case Study in Technology and Manpower," *New England J. of Med.*, Vol. 280, pages 1271–1277 and 1323–1329. June, 1969. A two part discussion of manpower requirements and supply in this field and its subspecialties. The articles present a good summary of the problem.

3. Moeller, D. W., "Meeting Radiological Health Manpower Needs," *American J. of Public Health*, Vol. 61, pages 1938–1946, October, 1917. Discussion of methods to increase the manpower supply in radiology, including recruitment, refresher training, and governmental assistance.

4. National Cancer Institute, Subcommittee for Training, *Crisis in Radiation Therapy Training and Practice*, Final report, September, 1972. Discussion of manpower situation in radiology, dealing with Therapeutic Radiology in particular and the urgent need for additional people, particularly for cancer therapy.

5. National Institute of General Medical Sciences, *Research Training in Radiology*, Report of the Radiology Training Grants Committee, June, 1971. Survey of manpower needs in nuclear medicine and diagnostic radiology, the elements of the present practice in these disciplines and the effect of Federal funds. Emphasis is placed on shortages in academic and research radiology.

6. Potter, K., *Manpower Needs in Cancer*, Graduate Training Committee of the National Cancer Institute, 1972. Discussion of problem areas in therapuetic radiology and medical oncology with projected manpower requirements for the future.

7. Willis, P. D., "Physician Assistants in Radiology," *J. Florida Medical Assistants*, Vol. 58, pages 36–37, September, 1971. Discussion of the use and importance of physician assistants in Radiology.

PART II—ONGOING MANPOWER STUDIES

1. *Internal Medicine*—American Society of Internal Medicine—A demographic survey of their membership which consists of 11,000 board eligible and board certified internists. At the end of March, 9,000 questionnaires had been returned. The study should be complete by the end of December 1973.

√2. *Surgery*—Study of Surgical Services in the United States. A study of present utilization of surgeons and its relation to training of the surgeon, the hospital setting and the demographic backgrounds of the population served; being done as a microanalysis of five different geographical regions and a macroanalysis based on a national questionnaire survey. The American College of Surgeons and the American Surgical Association. Study should be complete at the end of 1973. It is being funded jointly by DMI, BHME, and NCHSRD, HSA.

3. *Neurosurgery*—American Society of Neurological Surgeons. A study to evaluate the manpower resources and needs in the discipline of neurosurgery. The $50,000 contract funded by the National Institute of Neurological Diseases and Blindness.

√4. *Orthopedic Surgery*—Orthopedic Manpower Study, Phase III. Continuation of the study previously referred to, except that the direct observation of orthopedic practice has been extended to a national sample. The purpose of the overall study is to find out whether or not a new category of allied health personnel is needed for the orthopedist.

5. *Plastic Surgery*—Survey of Needs and Demands for Plastic Surgeons. Academy of Plastic Surgeons, Raymond Jurkiwicz, M.D. Questionnaire survey of all plastic surgeons as classified by the AMA. The questionnaire is based on the design and format of the SOSSUS questionnaire. Study should be complete by December 1973.

6. *Thoracic Surgery*—Survey of Thoracic Surgeons funded by the National Heart and Lung Institute. A manpower survey of thoracic surgeons conducted by the American Association of Thoracic Surgery.

7. *Anesthesiology*—Gravenstein, J. S., et al, Anesthesia Manpower Requirements for Cuyvehoga County, Part III. A development of cost analyses of various personnel mixes for the delivery of anesthesia care. DMI contract. American Society of Anesthesiology—Study of Academic Manpower of Anesthesiology.

8. *Neurology*—American Neurological Association. A Study to Evaluate Manpower Resources and Needs in the Discipline of Neurology. Contract awarded by NINDS for $100,000. Duration: March 1972 to March 1973.

9. *Psychiatry*—NIMH—Follow-up study of former NIMH trainees and fellows—a questionnaire study by Dr. Millen Levine, Division of Manpower Training. The final results should be available in July 1973. American Psychiatric Association—data collection of distribution of psychiatric practitioners' time between public and private practice. American Association of Chairman of the Department of Psychiatry (AACDP). Study of history and potential of NIMH training programs. This will be available in the summer of 1973.

√Evaluation of Cardiology Training & Manpower Requirements NHLI (National Heart & Lung Institute).

THE NUMBER OF PHYSICIANS AS A CONSTRAINT ON DELIVERY OF HEALTH CARE

HOW MANY PHYSICIANS ARE ENOUGH?

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The belief that there is a severe shortage of physicians in the United States is widespread, and corrective measures to increase the supply have been undertaken. We have examined the validity of this belief, using as criteria inter alia general and infant mortality, morbidity statistics, comparisons with other countries, and the potential increase in the demand for services following the removal of financial constraints. We have found no unambiguous evidence of a shortage of physicians of the magnitude described. Nor is there likely to be a substantial increase in demand for physicians' services under a national health insurance program. There are shortages in geographical areas and in specialties, but the production of more physicians appears to be an inefficient remedy.

"When . . . we find ourselves entertaining an opinion about the basis of which there is a quality of feeling which tells us that to inquire into it would be absurd, obviously unnecssary, unprofitable, undesirable, bad form, or wicked, we may know that that opinion is a non-rational one, and probably, therefore, founded upon inadequate evidence. (1)

The American health-care system is and has been the subject of widespread criticisms which encompass the high and rising cost of medical treatment, the inequality of care, the use of inadequate facilities, and the critical shortage of physicians. (2–10) A shortage of physicians would be a serious impediment to any effort designed to improve the delivery of health care, but would also be that aspect of the problem most amenable to correction through expansion of existing medical schools, the establishment of new schools, and abridgement of the medical curriculum. However, the training of more physicians would involve large expenditures of money ($38 million for the establishment of a new medical school ten years ago (11) and of planning and administrative efforts. Financial and human resources would be diverted from other potentially beneficial endeavors. It is, therefore, essential to examine closely the premise that there is a critical shortage of physicians which is detrimental to the health of the nation.

The Layman Is Convinced.—The layman is convinced that there are too few physicians. This belief often derives from waiting months for an appointment and then sitting for hours in the waiting room. He may have difficulty finding a family physician or pediatrician, particularly one who will come to the home. He hears of towns that lack a physician despite new facilities and guarantees of income.

What to the layman constitutes irrefutable evidence of a shortage of physicians may be interpreted differently: that physicians organize their office hours poorly; that a patient is better seen at a well-equipped center than at home; and that some towns may be less attractive to live in than others.

Commission Reports on Health Manpower.—Over the past 20 years, a number of presidential and other commissions (2–8) have examined health care in the United States and uniformly have concluded that the number of physicians should be substantially increased. The commissions' estimates of present and future needs for physicians, and the standards upon which these estimates were based, are presented in Table 1.

There has been no agreement on what constitutes an ideal physician-population ratio, nor does any commission present data validating the use of a particular ratio as a standard. For example, the President's Commission on Heart Disease, Cancer, and Stroke states only that they were "assuming that this ratio is a reasonable measure of need. . . ." (4) Similarly, the Bane Committee admitted that it had chosen the 1959 ratio as a standard because ". . . the challenge presented by just maintaining the present ratio over the next 15 years is of such magnitude that it would be of little help to develop a more sophisticated index." (3)

TABLE 1.—SUMMARY OF REPORTS ON THE PHYSICIAN SHORTAGE

Reporting body and estimated shortage or future need for physicians	Standard used for estimated need	Date of publication
President's Commission on the Health Needs of the Nation (2):		
For 1960, United States needs: 7,000 more	To maintain the 1940 physician-population ratio of 133 per 100,000.	1953
11,000 more	To maintain the 1949 physician-population ratio of 135 per 100,000.	
24,000 more	To maintain the 1949 ratio and also meet projected military needs.	
43,000 more	To have 1 private physician per 1,000 civilian population and maintain 1949 levels in hospitals, schools and military.	
35,000 more	To bring all geographical areas with low physician-population ratios up to the national average.	
62,000 more	To bring all geographical areas up to a ratio of 166 physicians per 100,000 population. All estimates based on projected 1960 population of 171,176,000.	
Surgeon general's consultant group on medical education (The Bane Committee) (3): Need to graduate 3,600 more per annum.	To maintain the 1959 physician-population ratio of 141 per 100,000 through 1975. Estimated 1975 population—235,246,000.	1959
President's Commission on Heart Disease, Cancer, and Stroke (4): Existing shortage of 20,000 physicians. Need to graduate 1,000 more per annum and increase to 1,300 more by 1975 to raise total by 57,000.	Based on standard of 1 private physician per 1,000 civilian population. To maintain the 1965 physician-population ratio of 149 per 100,000. Based on estimated 1975 population of 230,000,000.	1965
Task Force on Health Manpower (5): Existing shortage of 35,900 physicians. Need for 54,800 more by 1975.	To bring every low State's physician population ratio up to the national average. To maintain the 1965 physician-population ratio of 153 per 100,000. Based on estimated 1975 population of 232,221,000.	1967
U.S. Public Health Service (6): Existing shortage of 53,000 physcians in1966. Need for 103,000 more by 1975.	Based on standards of 100 physicians exclusive of hospital staff per 100,000 population, which is average ratio of prepaid group practice plans.	1967
National Advisory Commission on Health Manpower (7): Shortage exists because physician productivity is not keeping pace with demand for services. Future needs will depend on improvement in health-care system and physician productivity.	No numerical standard given for number of physicians in population.	1967
Carnegie Commission on Higher Education (8): Existing shortage of 50,000. Increase medical school entrants by 52 percent by 1978.	Quotes Dr. Roger Egeberg "To achieve physician-population ratios of 161.4 per 100,000 by 1977 and 216.4 per 100,000 by 2002."	1970

All of the reports on health manpower, except that of the National Advisory Commission, have arbitrarily chosen as standards physician-population ratios that existed at the time or had previously existed. They failed to delineate any relationship between the various ratios and the delivery of health care.

The arbitrary selection of ratios, the inaccuracy of population projections (12) and the failure to consider increased physician productivity or altered patterns of illness militate against an unquestioning acknowledgment of a shortage of physicians of the magnitude described.

Comparison With Other Nations.—That the United States physician-population ratio is low when compared with ratios of other nations is often cited as evidence of the shortage of physicians. The States, with 148 physicians per 100,000 population,(13) ranks tenth, far below the leader, Israel (Table 2). Yet the highest ratio is not necessarily ideal. With more physicians, medical services might become cheaper and more readily available. However, the training of more physicians might also result in an excess of physicians—a ratio which has also not been defined. If this should occur, unnecessary and repetitive services might multiply, and medical costs could well be higher.

The Carnegie Commission, citing evidence for a lack of physicians, pointed out that the United States ranks high in infant mortality.(8) However, of those countries with a higher ratio of physicians to population than the United States, five of the nine have a higher general mortality and all of the nine have a higher infant mortality (Table 2),(13, 14) Beyond some undetermined critical level, more physicians do not automatically reduce either the general or the infant death rates. For example, the Netherlands, where there is both a lower general mortality and a lower infant mortality than in the United States, (14) has only 117 physicians per 100,000 population. (13)

The unreliability of the national physician-population ratio as an index of a nation's health may also be shown by a comparison of the past with the present. In the United States in 1900, the physician-population ratio was 157 :100.000, (15) and the general mortality was 17.2 :1,000. (16) In 1967 the ratio had fallen to 153 physicians per 100,000, (11) while the general mortality had been reduced to 9.4 :1,000. (13) The effectiveness rather than the number of physicians has lowered the mortality, as illustrated by the leading causes of death in 1900. (15) These were as follows (per 100,000 population) : influenza and pneumonia, 202.2 ; tuberculosis, 194.4 ; gastritis, 142.7 ; heart disease, 137.4 ; vascular lesions affecting the central nervous system, 106.9 ; chronic nephritis, 81.0 ; all accidents, 72.3 ; malignant neoplasms, 64.0 ; certain diseases of early infancy, 62.6 ; and diphtheria, 40.3.

VITAL STATISTICS

An examination of the actual causes of mortality and morbidity in a country might indicate whether there is a shortage of physicians.

Mortality.—The ten leading causes of death in the United States in 1969, per 100.000 population, were as follows: diseases of the heart, 364.1 ; malignant neoplasms, 160.1 ; cerebrovascular disease, 102.0 ; accidents, 56.0 ; influenza and pneumonia, 34.7 ; certain causes of mortality in early infancy, 20.9 ; diabetes mellitus, 18.5 ; arteriosclerosis, 16.7 ; bronchitis, emphysema, and asthma, 15.6 ; and cirrhosis of the liver, 15.0. Table 3 gives the major causes of death in each age group. (17) In view of the causes of death, cancer, research, safer automobiles, the prevention of obesity, and the elimination of cigarette smoking would be more likely to lower the mortality than an increase in the number of physicians.

TABLE 2.—MORTALITY IN THE UNITED STATES AND IN COMPARABLE COUNTRIES WITH HIGHER PHYSICIAN-POPULATION RATIOS IN 1967

Country	General mortality per 1,000 (14)	Infant mortality per 1,000 live births (14)	Physicians per 100,000 population (13)
United States	9.4	22.4	153
Israel	6.6	25.9	236
U.S.S.R	7.6	26.3	221
Czechoslovakia	10.1	22.9	197
Bulgaria	9.0	33.1	174
Italy	9.7	33.2	175
Hungary	10.7	37.0	169
Austria	13.0	26.4	177
West Germany	11.5	22.9	163
Argentina	8.7	56.9	162

TABLE 3.—LEADING CAUSES OF DEATH BY AGE GROUP

Cause of death	Deaths per 100,000 (17)—Age years							
	1 to 14	15 to 24	25 to 34	35 to 44	45 to 54	55–64	65 to 75	75 plus
Diseases of the heart	0.7	2.3	10.6	66.2	239.2	665.4	1,629.7	4,578.6
Malignant neoplasms	6.6	7.7	16.5	62.0	180.4	420.2	770.3	1,171.2
Cerebrovascular disease	.5	1.6	4.4	15.7	43.5	116.4	406.2	1,603.5
Accidents	22.0	68.9	51.5	48.8	51.0	67.4	84.5	222.2
Influenza and pneumonia	3.4	2.7	4.1	9.4	18.2	40.5	106.9	429.6
Diabetes mellitus	.1	.8	2.8	9.0	19.4	42.6	94.2	185.3
Arteriosclerosis			0	.3	1.0	7.2	40.0	362.8
Bronchitis, emphysema and asthma	.3	.5	.6	2.6	9.9	38.0	89.4	138.4
Cirrhosis of the liver	.2	.8	5.3	19.5	37.8	48.1	38.9	24.5

The principal causes of infant mortality, per 1,000 live births, are as follows (17) : congenital abnormalities, 3.2 ; asphyxia of the newborn, unspecified, 2.7 ; immaturity, unqualified, 2.7 ; influenza and pneumonia, 2.1 ; birth injuries, 0.6; certain gastrointestinal diseases, 0.3; other diseases of early infancy, 5.8; all other causes, 3.4. None of these appear to derive from a shortage of physicians.

Morbidity.—It may be argued that the morbidity, rather than the mortality, would more accurately reflect a shortage of physicians. The prevalence of major chronic disorders in the United States, per 1,000 population, is as follows: arthritis and rheumatism, 63.9; chronic sinusitis, 58.5; asthma/hay fever, 54.3; hearing impairments, 34.1; high blood pressure, 30.8; heart conditions, 29.5; visual impairments, 17.9; hernia, 14.9; peptic ulcer, 14.4; chronic bronchitis, 11.7; diabetes, 9.0; and paralysis of major extremities or trunk, 5.5. (18)

Although these conditions do require long-term medical management and more physician-hours per patient than the usual brief illness, increasing the number of physicians would do little to reduce the *incidence* of these conditions.

Other major health problems not reflected in the above mortality and morbidity rates include alcoholism, drug addiction, and mental illness. In 1968 there were 409,606 residents of state, county, and private mental hospitals and 576,734 terminations of treatment at outpatient clinics. (12) If added to this were an unknown number of patients under private care as well as an estimate of the number of patients who continue at clinics, the full extent of mental illness in this country would still be unknown, as not all who are ill seek treatment. (19) Both the need for and the cost of medical services for the mentally ill is overwhelming. More physicians would not alleviate the situation, for the real need is for more effective methods of treatment. The same considerations apply to programs for alcoholics and drug addicts; an increase in the supply of physicians would be of slight help if the effectiveness of such programs was to remain at its present level.

TABLE 4.—REGIONAL PHYSICIAN-POPULATION RATIOS AND MORTALITY

Region	Physicians per 100,000 (1965)(6)	Deaths per 100,000 (1969)(17)	Infant deaths per 1,000 live births (17)
Middle Atlantic	171	10.2	20.9
New England	168	10.0	18.4
Pacific	157	8.5	18.3
East north-central	120	9.4	20.2
South Atlantic	116	9.5	23.1
Mountain	115	8.2	20.9
West north-central	114	10.3	18.2
West south-central	101	8.8	21.5
East south-central	89	10.0	25.0

TABLE 5.—UTILIZATION OF MEDICAL SERVICES BY THE ELDERLY

	Before medicare (1964[34] [35])	Under medicare (1968[32] [35])
Visits to physician's office:		
Total (millions)	72	84
Per person	4.23	4.20
Visits to hospital clinics:		
Total (millions)	9.6	10
Per person	0.56	0.50
Percent receiving hospital care	13.7	21.2

TABLE 6.—UTILIZATION OF HOSPITAL SERVICES IN ENGLAND AND WALES[1]

	1948 (37) (millions)	1968 (38) (millions)	Percent change
Inpatients discharged or deceased	2.97	5.15	73.0
Total outpatient visits	44.38	46.82	5.5
Population	42.94	48.59	13.0

[1] Before and after the establishment of the National Health Service.

PROBLEMS OF DISTRIBUTION

Geographical Maldistribution of Physicians.—There is convincing evidence of a national maldistribution of physicians. The physician-population ratios, given in Table 4, are higher in certain regions than in others, but, as also shown in the same Table, mortality is not substantially lower in areas with greater concentrations of physicians. (6, 15) The infant death rates are identical in the Middle Atlantic area, where there are 171 physicians per 100,000 population, and in the Mountain region, where there are 115/100,000. The data do tend to show that general mortality is higher in urban areas. The high infant mortality in the South may reflect a scarcity of physicians or the prevalence of unskilled rural midwives, (20) a tradition which may persist despite additional physicians.

Shortages Within Medical Specialties.—In a survey by Knowles of 18 specialty boards in the United States, (21) shortages were reported in anesthesiology, dermatology, internal medicine, obstetrics and gynecology, pathology, pediatrics, psychiatry, radiology, and urology. Other specialties reported either a sufficiency or a surplus; few did not respond. There is, however, no recognized optimal number of physicians for any given specialty. The individual boards estimated their ownneeds, and the validity of such estimates may be questioned. For example, the American Board of Dermatology reported that, although 5.6% of hospital outpatients and 3% of all inpatients have some dermatological disease, only 1.4% of practicing physicians are dermatologists. Yet there is no reason for the number of physicians in a specialty to be directly proportional to the number of patients with a particular type of disorder.

A greater production of physicians might not eradicate any shortages which do exist within particular specialties, as certain fields, for whatever reasons, are simply more attractive than others. It has been suggested that the training of more physicians would cause a "spillover" into less-favored specialties or into less-desirable geographical areas. In the past, however, physicians have chosen their geographical and professional areas according to their own backgrounds and interests, and they will probably continue to do so. (22) The spillover effect might operate only if there were a great excess of physicians.

Shortage of Primary Physicians.—A recent study (23) concluded that twice as many pediatricians and internists were needed in order to provide good primary medical care. The estimates of the necessary primary services were made by university-affiliated physicians whose individual judgments of need showed substantial variation (24) and might not accord with estimates of practitioners in other areas or with other affiliations. To extrapolate their estimates to the entire country may not be justified. Furthermore, a large and increasing proportion of primary care is being provided by neighborhood clinics, by ambulatory services at hospitals, and also by many specialists. If it is conceded that there is a shortage of physicians engaged in the delivery of primary care, the remedy would not be to train more physicians, only a part of whom would eventually engage in primary-care delivery. A less costly and more efficient approach would be the expansion of clinics and hospital ambulatory services. The case for a substantial increase in the number of primary physicians would be strengthened by evidence that the present shortage is detrimental to the health of the public.

Foreign Medical Graduates.—It has been suggested that the large number of foreign medical graduates accepted for hospital staff positions each year helps to mask the actual shortage of physicians in the United States. (7, 25) Certain specialties do depend heavily upon foreign graduates. In 1963 there were 29,295 foreign physicians holding resident positions in the United States; specialties with a particularly high percentage of foreign residents included general, or family practice, 52%; proctology, 50%; anesthesiology, 38%; pediatric cardiology, 36%; pathology, 34%; and pediatrics, 33%. (26) In some specialties, however, the large number of foreign graduates on hospital staffs may be evidence of a surfeit of training positions rather than an indication of a shortage of physicians, as appears to be the situation in England. (27)

THE COST FACTOR

Possibly, concern over the high cost of services may be restricting the demand for medical care. If so, a reduction in or an elimination of costs would soon uncover a preexisting shortage of physicians, and more physicians should be trained in anticipation of the establishment of a national health insurance or similar plan.

Medical Care and the Poor.—In 1959 the US Public Health Service reported that, as measured by visits per capita to physicians, families in higher income groups receive more medical care than those in the lower income groups. (28) A Blue Cross survey in 1963 found that both hospitalization and physician visits were more frequent for those with single or multiple health insurance than for those with neither. (29) Thus, before recently initiated government aid programs, financial constraints may have been restricting the demand for health care.

Strauss (30) and others have insisted, however, that it is not a lack of money which prevents the poor from obtaining health care but rather a lack of trust in and familiarity with the health-care system and a concomitant reluctance to seek medical care. This contention is supported by a recent study of health behavior after enrollment in the New York Medicaid program (Title XIX). (31) It was found that children of poor families, although assisted financially, "were still more likely to receive less care, to depend more on public clinics, and to have a higher proportion of illness-related than preventive medical contracts." (32)

Apparently, cultural impediments or deficiencies within the system of health-care delivery are greater barriers for the poor than are financial considerations. These handicaps would not be resolved by a greater abundance of physicians.

Medicare and the Elderly.—Medicare, which began in 1966, in effect equalized the money available for health care for all Americans over the age of 65 regardless of socioeconomic group. In 1968 there were 19.8 million elderly persons in the United States, of whom 18.8 million were enrolled for supplementary non-hospital coverage as well as the standard hospital benefits. (32) During 1969, Medicare paid 66% of the hospital bills and 72% of the physician bills for elderly citizens. (33) Table 5 compares data on the utilization of medical services before and after the implementation of Medicare. The number of visits to physicians has increased under Medicare, but at a rate little faster than the increase in the elderly population. The number of visits per elderly person has remained fairly constant. (34, 35) On the other hand, the rate of hospitalization has increased greatly. (35, 36) Thus, the increase in demand has been for hospital rather than for physicians' services. Although there may indeed be a need for expansion of some hospital services, the need for a large increase in the number of physicians to treat the elderly has not been apparent.

The British Experience.—The National Health Service went into effect in Great Britain on July 5, 1948. Table 6 compares 1948 and 1968 in terms of population growth and utilization of hospital services. Data on visits to physicians outside of the hospital clinics are not available. In 20 years, the increase in clinic visits was small when compared to population growth, while the demand for inpatient services increased greatly. (37, 38) It is unfortunate that the number of visits to physicians' offices has not been recorded in recent years, as it is not possible to obtain a total picture of the National Health Service without such data. Nevertheless, it is clear that, as under Medicare, it is primarily the rate of hospitalization which increases when the bill is not a burden.

Hospital Utilization and Prepayment Plans.—The need for expanded hospital services following the removal of financial constraints may not be as great as the above evidence would suggest. Utilization figures of prepaid group practice plans, including Kaiser-Permanente and the Health Insurance Plan of New York, show substantially lower rates of hospitalization and elective surgery than third-party payment plans such as Blue Cross. (39) If aspects of the prepayment scheme were incorporated into a national health plan, the increase in the utilization of hospital services might be less than presently anticipated.

PHYSICIAN PRODUCTIVITY

Resources under consideration for the training of more physicians might better be directed toward the development of more effective physicians. There has been little investigation into how the truly effective physician might be produced. All of the commission reports, except that of the National Advisory Commission, advocated increased production of physicians rather than increased physician productivity and effective use of time.

Physician productivity, however, can be improved with techniques presently available but not in widespread use. The utilization of the computer in health care is still in an embryonic stage and has been largely limited to clerical tasks in accounting, personnel, and inventory control in the pharmacy, blood bank, and kitchen. (40) In time, the computer could store and provide complete histories, aid in diagnosis, present the latest medical knowledge in a given field, and monitor the critical ill—all resulting in a vast saving of physician man-hours. Thus, the computer could both improve the quality of medical care and simultaneously increase the quantity of physicians' services available to the consumer. Physician time could also be expanded by the increased use of allied medical personnel. The training and deployment of more assistants to physicians would, probably for a small expenditure, increase the availability of physicians' services as surely as would the education of more physicians. In view of the resistance among physicians to the use of physician's assistants and computers,(41) appreciation and understanding of these human and electronic resources should be incorporated into the medical curriculum.

COMMENT

There is no unambiguous evidence of a critical shortage of physicians. The distribution of physicians, geographically and among the specialties, is uneven, but is unlikely to be corrected by an augmented output of physicians. Potentially more capable of effecting a redistribution would be a comprehensive federal program of financial inducement, as discussed by Ginzberg.(42)

The medical profession must heed the warning not to overrespond to the perceived health-care crisis and risk repetition of the present waste of manpower in the sciences.(43) Still forthcoming is a health-care master plan that would encompass personnel, physical facilities, expenditures, and the delivery of services, but, in the interim, emphasis should be upon the quality rather than the number of physicians. An increase in the number of physicians without accompanying changes in the entire system of health care seems unlikely to result in an advancement of the national health.

REFERENCES

1. Trotter WB: *Instincts of the Herd in Peace and War.* London, T. Fisher Unwin Ltd, 1922, p. 44.
2. *Building America's Health,* vol 2. President's Commission on the Health Needs of the Nation, 1953, pp 183–185.
3. *Physicians for a Growing America,* Public Health Service Publication 709. US Dept of Health, Education, and Welfare, Surgeon-General's Consultant Group on Medical Education, 1959, pp 1–13.
4. *A National Program to Conquer Heart Disease, Cancer, and Stroke.* President's Commission on Heart Disease, Cancer, and Stroke. Report to the President, 1964–1965, pp. 273–287.
5. *Action to Meet Community Needs.* Task Force for Health Manpower, National Commission on Community Health Services: Health Manpower. Public Affairs Press, 1967, pp 37–47.
6. *Health Manpower Perspective:* 1967, Public Health Service Publication 1667. US Dept of Health, Education, and Welfare, Bureau of Health Manpower, 1967, pp 9–14.
7. *Report of the National Advisory Commission on Health Manpower,* 1967.
8. Carnegie Commission on Higher Education: *Higher Education and the Nation's Health.* New York, McGraw-Hill Book Co Inc, 1970.
9. Cray E: *In Failing Health.* Indianapolis, The Bobbs-Merrill Co Inc, 1970.
10. Gerber A: *The Gerber Report: The Shocking State of American Medical Care and What Must be Done About It.* New York, David McKay Co Inc, Publishers, 1971.
11. *Medical School Facilities, Planning Considerations,* Public Health Service Publication 874. US Dept of Health, Education, and Welfare, pp 44–50.
12. *Statistical Abstract of the United States: 1970,* ed 91. US Dept of Commerce, Bureau of the Census, 1970, pp 6, 74.
13. *World Health Statistics Annual: Health Personnel and Hospital Establishments,* vol. 3. World Health Organization, Geneva, Switzerland, 1970, pp 39–42.
14. *Vital Statistics and Causes of Death,* vol 1. World Health Organization, Geneva, Switzerland, 1970, pp. 13–16.
15. Lerner M, Andersen OW: *Health Progress in the United States 1900–1960.* Chicago, University of Chicago Press, 1963, pp 16, 222.
16. Linder FE, Grove RD: *Vital Statistics Rates in the United States 1900–1940.* US Dept of Commerce, Bureau of the Census, 1943, p 127.
17. *Monthly Vital Statistics Report. Annual Summary for the United States 1969,* vol 18, No. 3. US Dept of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, 1970.

18. *Selected Health Characteristics by Area*, Public Health Service Publication C5. US Dept of Health, Education, and Welfare, National Center for Health Statistics, 1961, p 15.
19. Srole L, Langer TS. Michael ST, et al: *Mental Health in the Metropolis: The Midtown Manhattan Study*. New York, McGraw-Hill Book Co. Inc. 1962.
20. Buxton CL: *A Study of Psychophysical Methods for Relief of Childbirth Pain*. Philadelphia, WB Saunders Co, 1962, p 86.
21. Knowles JH: The quantity and quality of medical manpower. A review of medicine's current efforts. *J Med Educ* 44:81–118, 1969.
22. Ginzberg E: Cautionary view of medical care. *New Eng J Med* 262: 367–368, 1960.
23. Schonfeld HK, Heston JF, Falk IS: Numbers of physicians required for primary medical care. *New Eng J Med* 286:571–576, 1972.
24. Falk IS, Schonfeld HK, Harris BR, et al: The development of standards for the audit and planning of medical care. I. Concepts, research design, and the content of primary psysician's care. *Amer J Public Health* 57:1118–1136, 1967.
25. Margulies H, Block LS: *Foreign Medical Graduates in the United States*. Cambridge, Harvard University Press, 1969, p 82.
26. West K: Foreign interns and residents in the United States. *J Med Educ* 40:1110–1129, 1965.
27. Godber G: Trends in specialization and their effect on the practice of medicine, in Farndale J (ed.): *Trends in the National Health Service*. New York, The MacMillan Co, Publishers, 1964, p 59.
28. *Medical Care, Health Status, and Family Income*. Public Health Service Publication 1,000, series 10, No. 9. US Dept of Health, Education, and Welfare, National Center for Health Statistics, 1964.
29. Comparisons of the uninsured, those with one policy, and those with multiple coverage. *Blue Cross Rep* 5:1–8, 1967.
30. Strauss AL: Medical organization, medical care, and lower income groups. *Soc Sci Med* 3:143–177, 1969.
31. Roughmann KJ, Haggerty RJ, Lorenz R: Anticipated and actual effect of medicaid on the medical-care patterns of children. *New Eng J Med* 285: 1053–1057, 1971.
32. *Health Insurance for the Aged: Number of Persons Insured, July 1, 1968*. US Dept of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, April 15, 1970 (HI–17) p 1.
33. *Medical Care Outlays for Aged and Non-Aged Persons 1966–69*. US Dept of Health, Education, and Welfare, Office of Research and Statistics, *June 18, 1970*, Note No. 7, p 1.
34. *Volume of Physician Visits*, Public Health Service Publication 1,000, series 10, No. 18. US Dept of Health, Education, and Welfare, National Center for Health Statistics, 1965, p 13.
35. *Current Medicare Survey Report, Medical Insurance Sample*. US. Dept of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, CMS–12, Jan 27, 1970.
36. Epstein LA, Murray JH: *The Aged Population of the United States*, Research Report 19. US Dept of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, 1967, p 115.
37. Great Britain Ministry of Health: *Report for the Year Ending 31st March 1949*. London, His Majesty's Stationery Office, 1950, pp 19–354.
38. Great Britain Central Statistical Office: *Annual Abstract of Statistics No 106, 1969*. London, Her Majesty's Stationery Office, 1969, pp 7, 59.
39. Somers HM, Somers AR: *Medicare and the Hospitals*. The Brookings Institution, 1967, p 63.
40. Rutstein DD: *The Coming Revolution in Medicine*. Cambridge, Masachusetts Institute of Technology Press, 1967, pp 96–99.
41. Scott B, Meyer P: What physicians think about computers, transplants, and the "PA." *Med Opinion*, 1971, p 46–48.
42. Ginzberg E: *Men, Money, and Medicine*. New York, Columbia University Press, 1969, pp 266–267.
43. Fink DJ: Health care crisis. *Science* 173:766, 1971.

[Special article]

NUMBERS OF PHYSICIANS REQUIRED FOR PRIMARY MEDICAL CARE *

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Abstract This study was designed to develop estimates of the numbers of physicians required for the provision of "good" primary medical care. The estimates concerning pediatricians and internists are based on clinical judgments of the content of good primary care and the frequency of conditions requiring it. The data available indicate the need for 133 physicians per 100,000 persons for primary care, as against the available supply of about ½ as many. To overcome this marked shortage various measures have to be considered, such as increasing the number of medical students, decreasing physicians' nonpatient care time, transferring activities to other types of providers, reducing physician time spent on particular services and accelerating the development of group practices.

Shortages of health manpower are among the most important reasons for the current "crisis in medical care." Not the least of these shortages is that for physicians for primary care. The deficiency began to appear decades ago, as more physicians engaged in the specialities and fewer in general practice. Strong efforts have been made in recent years to moderate if not to reverse that trend, but the shortage persists. How severe it is, and what needs to be done to overcome it, involves complex questions on how to foresee future clinical practices and physicians' roles, and how to measure future manpower needs against current and currently prospective resources. Empirical projection from current levels of supply in relation to future levels of population has been a convenient but not a wholly satisfying procedure, even when coupled with assumptions and estimates about changes in demand for service.

Granting that there is a shortage of primary physicians now, how large or severe is it? By what standards shall we measure it? By what standards shall we try to anticipate and to plan against future needs?

As with questions about the supply of primary physicians, so also about the supply of physician manpower as a whole. We are therefore presenting here a method for estimating health manpower required for the availability of good medical care. With some modification, it also provides a way to estimate the associated facilities that are needed, and the costs. The method, first used in the Lee–Jones report of 1933 conducted under the direction of one of us (I.S.F.),(1) rests basically on professional opinion of services needed for good medical care, and on estimates of the incidence and prevalence of conditions requiring care.

Because of limitations in currently available data. our own and that provided by others, we can at this time apply our methodology only to the estimation of the required number of primary physicians. Our studies are in process of extension to all types of personnel so that they will enable us to prepare estimates for all kinds of services needed for the gamut of medical care.

These present estimates are concerned only with the care that, by professional judgments, internists and pediatricians should be providing as primary physicians for all personal health needs except those relating to dental, mental and obstetric problems and "routine physicals" for adults—though not excluding physician manpower requirements for well-child care. Our studies consider the providers of primary care as internists and pediatricians, though we are aware that in many communities and for many persons, it is not these practitioners but rather the general (or family) physicians who are actually providing such care. These manpower estimates might need some adjustment if based on the assumption that general practitioners, instead of internists and pediatricians, were providing the primary care.

METHODS

In general, the methodology for preparing estimates is conceptually simple, but it requires a large amount of detailed information.(2) Three basic kinds of data relating to pediatrician and internist services are necessary for each category of disease or condition requiring professional care: the average number of serv-

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ices of each kind that should be provided by the practitioner; the average amount of service time that should be involved for each unit of service of a particular kind; and the number of persons in the population that should receive the specified kinds and amounts of service from the primary physician, having regard for age, sex, incidence and prevalence of the disease or condition requiring care.

Using these kinds of data, we can calculate the total amount of service time—per episode of illness, per person per year, etc.—that a particular type of physician should spend in providing good care. Then, the conversion of service time into manpower estimates applicable to a population group only requires application of the average amount of time that primary physicians devote to patient care.

For this specific study, the basic clinical data for number of services and time per unit of service have been accumulated from 617 interviews with physicians, expressing the judgments of 24 pediatricians and 55 internists[1] regarding what should be done to provide good care in each of 80 diseases occurring in children and 170 diseases of adults.(2–5) All these physicians were in private practice and were members of the clinical faculty at the Yale-New Haven Medical Center when interviewed.

In the context of this study, the estimated average service time required per person seeking primary-physician attention refers to the time required of primary physicians for providing care whether in a single episode, in multiple episodes, over a first year and for each year beyond the first in which care was considered to be indicated. Attention required for "flare-ups," as well as for "maintenance" or "routine" care, was also taken into account.

The needed data on incidence and prevalence of diseases and conditions requiring care were developed from information provided by the National Center for Health Statistics (NCHS)—Health Services and Mental Health Administration, Public Health Service—from its published reports(6,7) and through special supplementary communications covering the period July, 1965, to June, 1967.[2]

Preparation of Estimates

Estimates of the primary physician manpower required for providing good care for persons with acute conditions were prepared as follows:

For each Recode 2 grouping of acute diseases in the data of the NCHS, a total amount of service time required for primary-physician attention was calculated from the number of acute conditions reported by the NCHS for which physician attention was said to have been sought, and the average amount of time required for primary-physician attention for that grouping, as estimated from our physician-interview data.

This estimated total amount of service time was divided by 2227 hours for pediatricians and 2198 hours for internists(8) to give the estimated required number of primary physicians of each kind. It should be noted that the latest information for 1968–69 on hours spent for patient care indicates that pediatricians spend 2256 hours per year and internists 2285 hours.(9) The former data were used for this study, however, since they applied to the same period as the incidence and prevalence data.

Corresponding estimates of primary-physician manpower required for attendance on persons with chronic conditions were prepared as follows:

For each Recode 3 grouping of chronic disease in the NCHS data, yearly average total amounts of service time required for primary-physician attention for "first-year" and for "carry-over" chronic conditions were estimated by means of methods similar to those used for acute conditions.

The estimated yearly average total amounts of service time for "first-year" and "carry-over" care also were divided by 2227 hours for pediatricians and 2198 hours for internists. This estimation of manpower assumes independence of care required for multiple simultaneous chronic conditions.

Adjustments were then made for the estimated number of primary physicians required for good care for chronic conditions on the assumption of simultaneous care for coexisting chronic conditions.

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[1] The names of the pediatricians and internists interviewed are listed in previously published studies. (2–5)

[2] Supplementary personal communications provided data for the National Center for Health Statistics Recode 2 categories for the number of conditions and the proportion of acute conditions for which physician attention was sought. For Recode 3 categories, data were provided on the number of conditions. Acute data were for the period July, 1965, to June, 1966, and chronic data for July, 1965, to June, 1967.

With the use of the manpower estimates separately determined as required for acute and chronic conditions, derivative estimates were prepared for the manpower required per 100,000 persons.

Estimates were also prepared for the primary-physician pediatrician manpower required to provide well-child care to 100,000 children under the age of 17, and for discussions with the mothers (5,500) expected to give birth to the children (5,600) included in the total of 100,000 children. These estimates took account of the estimated numbers of mothers and children (by age) that should receive care, and the average amount of pediatrician's time required per mother or per child.[3]

It must be recognized that in the preparation of the manpower estimates, various assumptions were made regarding the reporting of the acute and chronic conditions, the seeking of attention and the types of physicians providing care. Moreover, the interviewed physicians of this study are mainly in solo or limited partnership practice in one geographical area (New Haven, Connecticut), and their opinions apply to only one point in time—the present. It may therefore be necessary to have these current views and the derivative standards of what constitutes good care reviewed by physicians in other parts of the country and in other types of practices, especially in group practices, to develop alternative standards. Also, as the underlying science and art of medical practice change, the judgments of practitioners on what constitutes good medical care will change, and currently developed standards will have to be up-dated periodically.

RESULTS [4]

Primary-Physician Manpower for Acute Conditions

Table 1 shows the estimated numbers of pediatricians and internists that would have been needed as primary physicians to provide good care for acute conditions, shown according to broad groupings of disease and by population age.

By current professional judgments, 100,000 children under the age of 17 should have received annually the services of nearly 55 pediatricians for good primary care of their 180,000 acute conditions requiring care. Each condition should have required, on the average, slightly less than two visits for diagnosis and treatment, the average visit being about 20 minutes in duration.

TABLE 1.—PRIMARY PHYSICIANS REQUIRED FOR GOOD CARE OF PERSONS WITH ACUTE CONDITIONS

Conditions	Physicians/100,000 persons in each age group			
	<17 yr	17–64 yr	65 yr and over	All ages
All acute	[1] 54.7	70.0	52.2	[1] 63.0
Infective and parasitic	7.4	8.0	4.2	7.4
Respiratory	27.8	20.8	12.1	22.4
Digestive	2.3	3.5	7.5	3.4
Injuries	8.0	18.7	7.6	13.9
All other	9.3	19.0	20.8	15.8

[1] Totals differs from sum of column owing to rounding off.

Similarly, approximately 70 internists would have been needed to provide good primary care for 100,000 adults 17 to 64 years of age with 109,000 acute conditions, and 52 internists to provide the necessary services for 100,000 adults 65 and older with 81,000 conditions. Each condition should have required almost three visits for diagnosis and treatment, the average visit being slightly less than 30 minutes.

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[3] For the population of 100,000 children used in these estimates, it was assumed—for convenience of calculation—that there were equal numbers of children in each yearly age group. This crude method of estimation does not take into account differential death rates by age or the differing birth rates over the years.

[4] For more detailed information on the numbers of acute and chronic conditions requiring care and the numbers of primary-care physicians estimated, order NAPS Document 01733 from National Auxiliary Publications Service, c/o CCM Information Corporation, 866 3d Ave., New York, N.Y. 10022; remitting $2 for each microfiche-copy reproduction or $5 for each photocopy. Checks or money orders should be made payable to CCM Information Corporation——National Auxiliary Publications Service.

Attendances include the physician's office, the patient's home, the emergency room, the hospital outpatient clinic, the hospital bedside and the nursing home, according to the requirements of care for the attended condition.

Primary-physician manpower for chronic conditions

As stated previously, our methods of estimating primary-physician manpower requirements for the care of persons with chronic conditions allow for distinction between the care needed for people with new (first-year) chronic conditions and that needed for those with conditions regarded as having been carried over from a previous year. Combination of these estimates gives the number of primary physicians required for good medical care for a mixture of both first-year and carry-over cases.

Table 2 shows, in summary form, that slightly more than 22 pediatricians would have been required to provide good primary care to a population of 100,000 children under 17 years of age having a mixture of 29,000 first-year and carry-over chronic conditions in any year. For 100,000 adults 17 to 64 years of age, 92 primary-physician internists would have been needed for the care of 120,000 chronic conditions, and for 100,000 adults 65 years and over, 228 internists would be needed for 269,000 conditions.

TABLE 2.—PRIMARY PHYSICIANS REQUIRED FOR GOOD CARE OF PERSONS WITH CHRONIC CONDITIONS (ASSUMING EACH CHRONIC CONDITION TREATED INDEPENDENTLY)

Conditions	Physicians/100,000 persons in each age group			
	<17 yr	17–64 yr	65 yr and over	all ages
All chronic	[1]22.1	92.1	227.8	80.2
Neoplasms	1.6	7.1	12.0	5.6
Allergic and respiratory	11.1	15.7	20.5	14.5
Circulatory	.7	19.3	57.3	16.3
Digestive	.4	10.4	27.7	8.5
Genitourinary	.5	3.5	6.8	2.8
Muscles, bones, joints	.2	7.3	23.2	6.3
Paralysis, impairments, fractures, injuries	3.8	14.0	38.3	12.7
Other chronic	3.9	14.8	41.9	13.5

[1] Total differs from sum of column owing to rounding off.

If we assume, however, that physicians care should be provided simultaneously for all existing chronic conditions, whether first-year or carry-over, we must take into account the average number of chronic conditions per person having such multiple conditions. Available data indicate that the adjustment values are approximately 1.3 conditions per child under 17 years of age, 2.1 per adult 17 to 64, and 3.33 per adult 65 and older (7). Using these values as adjustment factors, we have estimated the number of primary physicians needed to provide simultaneous primary care for all the chronic conditions afflicting these populations. This procedure gives manpower figures that are too low, even as the procedure assuming independent care gives estimates that are too high. We have therefore also taken averages of the two series, and the three sets of figures are shown in Table 3.

With the use of the average of the calculations for independent and simultaneous care of chronic conditions, each child under 17 years of age should have had almost 1½ visits annually for care of chronic diseases, each visit being of about 18 minutes' duration. Adults under the age of 65 should have had slightly more than three visits per year with each visit being almost 30 minutes, on the average. Adults 65 and over should have had almost seven visits per year for care of chronic conditions, the average visit being slightly less than 30 minutes.

Physician manpower for well-child care

In addition to illness care, a population of 100,000 children under the age of 17 should require the services of almost 28 pediatricians for well-child care. The 5,600 newborn infants included in this group should require care from approximately four pediatricians during their initial stay in the hospital. Also, the almost 5,500 mothers should have required the services of nearly one pediatrician for services before and after delivery.

TABLE 3.—PRIMARY PHYSICIANS FOR ANNUAL CARE OF CHRONIC CONDITIONS PER 100,000 PERSONS IN THE AGE GROUPS INDICATED

Assumption concerning care for multiple chronic conditions	Pediatricians—For ages <17	Internists	
		For ages 17 to 64	For ages 65 and over
Independent care	22	92	228
Simultaneous care	17	44	69
Average of both	20	68	148

Summary of physicians needed for good primary care

Bringing the various estimates together, we have the figures shown in Table 4, which summarizes the numbers of physicians needed—by current professional judgments and standards—for the provision of good care for acute and chronic conditions, and for newborn and well-child care. In addition to showing the numbers per 100,000 persons in each age group, we have expressed the figures as the numbers per 100,000 of the general population of all ages.[5] On this basis, it appears that primary medical care of good quality requires the services of about 133 physicians per 100,000 persons of all ages in the population. As indicated earlier, this is exclusive of primary physician care for most mental and obstetric conditions, for dental care, and for routine physical examinations of adults. For a current average total population of about 200 million, this means about 266,000 physicians for primary medical care.

We should emphasize the fact that these estimates indicate the numbers of physicians needed for good primary care according to the judgments and standards of good care expressed by internists and pediatricians who are engaged in providing primary care (whether or not also practicing in a nonsurgical subspecialty) and by the prevalent patterns of performance among these community physicians engaged in solo or partnership practice.

TABLE 4.—SUMMARY OF PHYSICIAN MANPOWER REQUIRED FOR GOOD PRIMARY CARE PER 100,000 PERSONS IN THE RESPECTIVE AGE GROUPS

Type of care	Pediatricians—For ages <17	Internists		For all ages		
		For ages 17 to 64	For ages 65 and over	Pediatricians	Internists	Both
All primary care [1]	[2] 106	138	200	37	96	133
Acute care	55	70	52	19	44	63
Chronic care	20	68	148	7	52	59
Newborn and well-child care	32			11		11

[1] Excludes dental, mental and obstetric care and routine physical examinations for adults.
[2] Sum differs from total owing to rounding off.

DISCUSSION

Comparison of available and needed physicians for primary care

To appreciate the relevance of these estimates to present and future requirements for physician manpower, our figures should be compared with the present number of physicians engaged in furnishing primary care. Unfortunately, the comparison cannot be made easily for lack of data on the number of physicians actually engaged in furnishing primary care or available to provide it. It is therefore necessary to derive an approximation of the number of primary-care physicians. Using the available data on numbers of general practitioners (M.D.), internists, obstetrician-gynecologists, pediatricians and osteopathic physicians (D.O.) thought to have been available for primary care (10–14), we arrive at estimates of about 65 nonfederal physicians available for primary care in 1966 per 100,000 persons in the civilian population, and even somewhat fewer—about 59 per 100,000 persons—in 1970.[6]

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[5] These calculations used the proportions of children and adults in the civilian population of the United States as of 1966 and 1967, the years to which the numbers of acute and chronic conditions applied.

It is now evident that the number of physicians estimated to have been available to furnish primary medical care has been about ½ the number required to furnish medical care according to physicians' standards on the content of good care. Obviously, with a shortage of this magnitude in the supply of physicians for primary care not all who require such care can receive it. What now occurs is that some people receive no primary care, some receive only part of the needed care, and only some fraction of the population receives all necessary primary care indicated by current clinical standards and judgments.

Ways of narrowing the gap in the physician supply (*15*)

Obviously, the best solution to the physician shortage would be to eliminate the need for many of the physician services by preventive and other measures that would decrease the incidence of disease and reduce the prevalance of accompanying complications and resulting disabilities. This resort should, of course, be pursued as vigorously as possible, but since it cannot be expected to reduce a substantial portion of the need for good primary care in the immediate future, various other approaches consistent with the objective of good medical care for the population must be sought. If altogether adequate solutions cannot be found, continuing compromises will have to be made, and these should be guided by concern for the best that is feasible in patient care.

The most widely advocated solution is to increase the number of physicians available for patient care. Though being pressed vigorously, with support from both the government and the private sector, it cannot even hope to overcome in the near-time future more than a fraction of the gap disclosed by our data; even a considerable increase in the total number of physicians carries only limited assurance that it will lead to substantial augmentation in the numbers available for primary care.

Another approach is to increase the proportion of the physician's professional time that can be made available for patient care by relieving him of many of his nonpatient-care activities. Various organizational settings, such as group practice of substantial size, have large promise in this direction through ability to employ personnel to that end.

Such an increase in the physician's patient-care time as may be feasible cannot be so large as to reduce greatly the gap between the estimated manpower needed for good care and the manpower that is available now or is likely to be available in the near-time future for primary care. To narrow that gap to a manageable and acceptable level will require compromises, and these will have to involve modifications either in the standards of good care or in the methods of delivering care, or in both.

The approaches for reducing the primary physician manpower gap may be further categorized according to whether they involve the type of provider for particular services, the kinds and quantities of service, or the physician time involved in providing the services. Of the suggested changes involving the type of provider, these usually have to do with substituting the services of a nurse clinician (nurse practitioner), of a physician's assistant or of other supporting personnel for those of the physician, and many such undertakings are under way. If the substitute personnel are well trained for the services that they are to provide under the direction of the physician and they are used discriminatingly, there may be no loss in good patient care, and indeed there may be gain, so that this becomes an acceptable compromise. Its promise of contributing appreciably to narrow the manpower gap may depend in large measure on the growth of group practice and the development of skill in utilizing the assisting personnel.

Changes concerned with service have to do with the substitution of some performances that take less of the physician's time for others that take more of his time, or with a decrease in the quantity of services, or with both. Any such approaches must obviously be weighed carefully to assure that their contributions to reduction of physician manpower shortage are not at the price of deterioration in adequacy of patient care.

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[6] The first of these estimates of primary-care physicians is based on 1966 data because that is the year that approximates the period for which the NCHS data on morbidity were available for use in Tables 1--4. The second estimate (for 1970) uses the most recent data that are available.

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Our last approach involves the potential for reducing the time that the physician should spend in making his contribution to the spectrum of services required for good care. The time estimates that were involved in the standards recommended by our clinical colleagues and used in our derivative manpower estimates were based on the opinions of community practitioners. We have therefore to pose the question of the extent to which the reach of the physician supply can be extended through other arrangements for physician availability for delivery of care—especially through organized group practice and various combinations of ancillary personnel and facilities. We are under no illusion, however, that any or all of the measures that we have mentioned can be expected to close the gap between needed and available physician manpower for primary medical care rapidly.

Our estimates are not based on arithmetical projections from manpower trend lines of the past; they are based on newly enunciated clinical standards of what is needed for good medical care, and they reaffirm what has long been widely known—but they show the physician manpower shortage to be much larger than had been generally supposed. This, to be sure, is a manpower gap not between demand and supply but between true clinical need and supply. Thus, the estimates present a challenge not only to the dynamics of the current medical market place (which is not a new challenge), but also to the applicability of the potential for good medical care (which may not be new but has been little evaluated).

Our data suggest that—even with strong and determined effort—there is little or no likelihood that primary medical care of good quality and reasonable adequacy, by professional standards, can be available to the population as a whole in the discernible future. The best that we can hope for is well considered measures to improve the delivery of care so that the services that can be furnished are as effective and as beneficial as possible for those who need the services most.

References

1. Lee RI, Jones LW: The Fundamentals of Good Medical Care: An outline of the fundamentals of good medical care and an estimate of the service required to supply the medical needs of the United States. Chicago, University of Chicago Press, 1933
2. Schonfield HK, Falk, IS, Laviete PH, et al.: The development of standards for the audit and planning of medical care: good pediatric care—program content and method of estimating needed personnel. Am J Public Health 58:2097–2110, 1968
3. Falk IS, Schonfeld HK, Harris BR, et al: The development of standards for the audit and planning of medical care. I. Concepts, research design, and the content of primary physician's care. Am J. Public Health 57:1118–1136, 1967
4. Schonfeld HK: Standards for the audit and planning of medical care: with illustrations from myocardial infarction, Health Care Services for the Aged: Problems in effective delivery and use (Institute of Gerontology Series Vol 19). Edited by CC Osterbind. Gainesville, Florida, University of Florida Press, 1970, pp 107–137
5. *Idem:* Standards for the audit and planning of medical care: a method for preparing audit standards for mixtures of patients. Med Care 8:287–298, 1970
6. United States National Center for Health Statistics, Vital and Health Statistics. Bauer ML: Current Estimates from the Health Interview Survey: United States—July 1965–June 1966. Washington, DC, Government Printing Office, 1967 (PHS Publication No 1000, Series, No 37), pp 20, 33
7. United States National Center for Health Statistics. Vital and Health Statistics. Wilder CS: Chronic Conditions and Limitations of Activity and Mobility, United States—July 1965–June 1967. Washington, DC, Government Printing Office, 1971 (PHS Publication No 1000, Series 10, No 61), pp 19, 59
8. Theodore CN, Sutter GE: A report on the first periodic survey of physicians. JAMA 202:516–524, 1967
9. Balfe BE, Lorant JH, Todd CH: Reference Data on the Profile of Medical Practice, 1971. Chicago, American Medical Association, 1971, pp 50, 53

10. Theodore CN, Sutter GE, Jokiel EA: Distribution of Physicians, Hospitals, and Hospital Beds in the U.S., 1966. Vol 1. Regional, state, county. Chicago, American Medical Association, 1967, pp 48–53
11. Haug JN, Roback GA, Martin BC: Distribution of Physicians in the United States, 1970: Regional, state, county, metropolitan areas. Chicago, American Medical Association, 1971, pp 54–59
12. United States Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics. Health Resources Statistics: Health manpower and health facilities, 1968. Washington, DC, Government Printing Office, 1968 (PHS Publication No 1509), p 123
13. National Disease and Therapeutic Index: Annual report. Ambler, Pennsylvania, Lea Associates, 1968–69
14. *Idem:* NDTI Medical Report No 4: Study of obstetrics-gynecology. Ambler, Pennsylvania, Lea Associates, 1962
15. The medical manpower shortage, JAMA 217:1857–1859, 1971

Mr. Rostenkowski. Mr. Cotter will inquire.

Mr. Cotter. Thank you, Mr. Chairman. I would like to explore some of these costs, Mr. Woodcock, if you bear with me, costs for the program. We have seen health care costs increase some 13 to 14 percent per year. We have seen medicare, medicaid increase in that past 2 years from $11 billion to $25 billion.

What steps would you recommend to keep the costs of these ever-increasing costs down or stabilized?

Mr. Woodcock. Through essentially a prebudgetary system which would work toward the elimination of extensive duplicative services and particularly extremely duplicative equipment and begin to bring some sense and balance and planning to the whole business.

Mr. Cotter. Such as having in one major city a heart hospital and in another hospital a kidney dialysis, that type of thing?

Mr. Woodcock. Yes, sir.

Mr. Cotter. Do you have any studies of what savings would be affected?

Mr. Woodcock. Well, we think we have an excellent laboratory to the north of us in terms of Canada that would have some good results to show over a relatively short period of time in this respect.

Mr. Cotter. Does this in any way restrict the freedom of choice of physicians or the availability of services?

Mr. Woodcock. No, sir, Not essentially.

Dr. Falk. I would like to add a point.

Mr. Cotter. Yes, Doctor.

Dr. Falk. I am sure Congressman Cotter, you will not be surprised that in our State of Connecticut we now have a State commission—which is exercising initial——

Mr. Cotter. And they have done a reasonably good job. Have they not kept it to 10 or 11 percent, Doctor?

Dr. Falk. Yes, sir.

Mr. Cotter. Do you think improvement can be made in this?

Dr. Falk. Beyond any question, Mr. Congressman, that improvement can be effected. The experience is initial and brief but the promise is very considerable. And I think as the education and the awareness of the public increases, that intervention into this system, sanely, carefully, can lead to useful results, bringing public support and encouraging public authority to be more courageous and I think there are—than I think they now are.

Mr. Cotter. Is this program working without undermining the medical profession and the hospitals to your knowledge?

Dr. Falk. You are referring to our program in Connecticut?

Mr. Cotter. Yes.

Dr. Falk. Well, there is some pulling and tugging and hauling about it, but I think on the whole the focus on the restraints in the expansion of hospital resources and in the escalation of hospital operating costs and of hospital charges has been with no substantial effect on the performances or the practices of the physicians.

It is an early—in an early stage and it may be that if the cost controls are made more extensive and more effective, there will be some restraints which the physicians will resent, but I think that they ought to learn to live with cost controls that are reasonable even if they have an impact on the physicians.

Mr. Cotter. Are the physicians responsible or the hospitals responsible for these ever-increasing costs?

It appears that hospital costs are increasing at a much greater rate than medical costs.

Dr. Falk. In the main, both are, Mr. Cotter. The hospital system is the most extraordinarily badly designed system that man could conceive.

Mr. Cotter. I agree.

Dr. Falk. Especially since nearly all expenditures are determined by people not part of the hospital management or staff. The physicians determine most of what happens there and they are independent practitioners for the most part except for the few who are on the full-time hospital staff.

Some reconciliation must be effected in order to be able to keep the scope of services and the quality and costs of hospital care as well as physicians' care within the reach of mankind of this country. I think that if an evolutionary course is followed here, reasonably useful programs will evolve with some bloodletting, perhaps, and with some constraints and difficulties with which we will learn to live.

Mr. Cotter. Thank you. What concerns me, we hear these reports of a cost of anywhere from $118 billion to $127 billion. What concerns me is where is this money going to come from?

Dr. Falk. What was the last?

Mr. Cotter. The costs of health programs this year run anywhere from $118 to $127 billion. Even if we take these steps to keep costs down, you have to expect a 5 to 7 percent increase every year. Where is the money going to come from?

Dr. Falk. It is coming from all the sources that are financing this nonsystem system of medical care which we have in the United States. An increasing share of it is coming from the public fists, public treasuries, State and local; increasing proportions are coming from employers; increasing proportions are coming from their employees; increasing proportions are coming from everybody and the escalations which are going on are being financed in a crazy-quilt fashion with no effective restraints on incremental limits in the costs; the administration figures for last year indicate that when the books are closed on fiscal 1975 they will show that the national expenditures went up at least 13, more likely 14 percent, and even if we use as we have been doing in our studies, prospective escalations of the very modest rate of 11 percent, which is shocking enough, it means that all the sources of funds will be being taxed to make greater and greater strain on the economy.

Mr. COTTER. Thank you, Doctor. My time is up, but I would like to point out that even if payroll taxes were to pay 50 percent of this we have to look to the Federal Treasury for some $58 to $60 billion and even subtracting what we are already paying for medicare and medicaid. We still have a balance of some $35 to $40 million which the Federal Treasury has to pick up and I just do not know where it is coming from.

Dr. FALK. That, Mr. Cotter, is the best argument for the health security program because what you have just said is what is ahead most surely if we do not intervene with a program like the health security program and bring some restraints on these cost escalations.

Mr. COTTER. Let me conclude by saying that we have built increases in of $72 billion in Government deficit this year. You add another 50 to it and I think the country just cannot survive it.

Thank you very much, unless you wish to comment.

Mr. WOODCOCK. If I may, Mr. Chairman, in a petition which is filed with our statement, using the HEW methodology, it shows that by fiscal year 1978, nothing being done, the $118 billion this year will have escalated to $142 billion.

Mr. COTTER. Right.

Mr. WOODCOCK. Of which 38.7 would come from the Federal budget. By fiscal year 1982, however, it would have escalated to $222 billion of which $60 billion would come from the Federal budget. We agree that the country cannot afford it. And I understand that the committees of the Congress have to be very much concerned about what goes into the congressional budget. But you have to be concerned about the country because the fact is we are spending money at an overescalating rate and unless we begin to get our arms around the cost problems, it is going to become a totally unmanageable situation.

Mr. COTTER. I agree with you, that is why I wonder where the money is coming from. Thank you.

Mr. ROSTENKOWSKI. Mr. Woodcock, as I understand it, you are talking about a fixed budget under which health security would work; is that not true?

Mr. WOODCOCK. Yes, sir.

Mr. ROSTENKOWSKI. And it is your opinion that we can keep a fixed budget over a period of the next 4 or 5, 10 years and work within that fixed budget?

Mr. WOODCOCK. Well, obviously given our present situation there will be a continuation of inflation, but it really comes down to what degree will you control the inflationary spiral.

Mr. ROSTENKOWSKI. But the fixed budget would be open to an increase in what the inflationary spiral has brought on, would it not?

Mr. WOODCOCK. Dr. Falk is telling me that from one year to another there would be an adjustment for the basic underlying inflation.

Mr. ROSTENKOWSKI. So you would work within a calendar year on a fixed budget but that the budget would be moving as inflation would move?

Dr. FALK. In synchronization with what is happening in the economy as a whole.

Mr. Rostenkowski. Mrs. Keys will inquire.

Mrs. Keys. Thank you, Mr. Chairman.

Mr. Woodcock, it was a pleasure to hear your testimony and particularly some of the facts you pointed out about some of the major weaknesses in some other approaches.

I have a couple of questions I would like to ask. Would it not be fair to say that essentially all the dollars that amount to almost $120 billion this year that are being paid for health care in this country, come out of our pockets, every taxpayer, every individual citizen's pocket and they come out in different ways either directly to the health procedure, through private insurance, through some kind of Government taxes for the Government programs we now have, and that our need to do something about national health insurance is a need to channel these in the best possible way to provide access and coverage to all people?

Mr. Woodcock. Exactly, yes.

Mrs. Keys. I am concerned about the element of universality. Do you feel that is totally important and that if we really got rid of a needs test we would have to have universality as a major element?

Mr. Woodcock. We very definitely believe that, and again I think we can point out to some concrete experiences in some of the Canadian provinces that tried the corridor approach, the means test approach, and found that in fact it tended to have a negative influence on cost. It did nothing about bringing cost down. So they quickly abandoned it, I think it was some 2 years ago, and they went to a universal no-barrier approach.

Mrs. Keys. I am glad to hear you say that because it is very important to me. There are two areas which I see impacted greatly, and one is in the area of coverage of the unborn, or prenatal care. It has always struck me as a great assininity that somehow a woman has to be in the health insurance plan for 9 or 10 months before she is covered for pregnancy. Maybe that is fine from an insurance point of view but if we care about health care and healthy citizens that is a ridiculous concept to me. I think somehow whatever insurance or national health insurance we have, has to solve that problem right away and that our concern be for the care of that mother and unborn child—period.

There is another area that I am concerned with. I think it goes without saying that health care in this country is one of the areas in which there has still remained unfair treatment for women and for some of the major diseases of women. It is true that really there are very few private health insurance policies now which cover the pap smear which is a basic test, a basic diagnostic test for one of the major killers of women.

It seems to me that this is another factor that moves us to do something better about a national health care system that will be fair in their treatment of all citizens.

Would you agree?

Mr. Woodcock. Most definitely I agree. We are rather proud of the coverage the UAW has negotiated and it so happens that we were able to provide the pap smear test only as of October 1 of this year despite the fact we have been innovators in the health care approach over a good many years.

Mrs. KEYS. You are well-known for that and it is a privilege to hear your testimony this morning. Thank you very much.

Mr. ROSTENKOWSKI. Mr. Pike will inquire.

Mr. PIKE. No questions, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman. I will just welcome Mr. Woodcock and his associates to the committee and second Mrs. Keys' comments. I hope that you will continue as you have over the past years to work toward what I think is the only reasonable solution to the medical problems in this country. And maybe we can approach separating out health which may be better addressed outside of the medical profession.

Thank you for appearing.

Mr. WOODCOCK. Thank you, Congressman Stark, you have made my day. [Laughter.]

Mr. ROSTENKOWSKI. Are there further questions of the witness?

If not, Mr. Woodcock, I want to thank you for cooperating with the committee. You have been most helpful and we appreciate the time you have taken out to help us.

Mr. WOODCOCK. Thank you very much, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Ronald Brown.

Welcome to the committee, Mr. Brown. If you would identify yourself and your associate, you may proceed with your testimony.

STATEMENT OF RONALD H. BROWN, DIRECTOR, WASHINGTON BUREAU, NATIONAL URBAN LEAGUE, ACCOMPANIED BY ROBERT McALPINE, ASSISTANT DIRECTOR, WASHINGTON BUREAU

SUMMARY

A call to action.—The time for enactment of a national health insurance program is now.

Goals.—(A) Insure that each and every person, regardless of race, income or geographic location, has high qualtity, comprehensive, and dignified medical, dental, and mental health care; and (B) Be equitable, accessible, and feasible.

Reform is needed.—The present health care system has proved to be unworkable and unwieldy. Basic and sweeping reforms are necessary.

Financing.—A national health insurance program should function as a single trust fund operated by the Federal Government with funds from general revenues, contributory taxes, or a special surtax and should be patterned after the Social Security system. It should be on a pre-paid basis, thus eliminating the present fee-for-service structure.

Delivery of services.—A national health insurance program should provide for consumer participation in all of its functions and assure community control of facilities and programs that provide direct services; should insure equal access to quality health care to all persons; should encourage an increase in the number and availability of medical practitioners.

Education and training.—Such a program should provide free professional medical training open to any applicant in return for a five-year service commitment upon professional certification. This would serve to increase the number of physicians without discriminating on the basis of personal financial status, particularly among minorities. It should also provide for additional training to already licensed practitioners to upgrade the quality of their skills and service.

Equality of treatment.—There should be a single class of health services for all, with the same eligibility criteria applicable to all, and no physician being able to exact a higher price for his services than another except what might be warranted by experience and measurable skill.

Mr. Brown. Thank you very much, Mr. Chairman.

I am Ronald H. Brown, Director of the Washington Bureau of the National Urban League. With me is Mr. Robert McAlpine, Assistant Director of the Washington Bureau.

It is, of course, a pleasure to appear before you this morning on behalf of the National Urban League. As you may know, we had the opportunity to present testimony on this subject to the full committee in hearings about a year ago.

Last January, as you know, congressional leaders spoke optimistically of an early enactment of a national health insurance bill. Ten months later the Congress is yet to enact such legislation.

We recognize full well the careful and exhaustive deliberations which are necessary to draft and enact any meaningful and wide-ranging piece of legislation. However, national health insurance is an issue and a problem which has long been with us. It is now time for us to weigh the pros and cons voiced during those exhaustive deliberations and to enact the necessary legislation which will meet the ever-pressing and increasing needs of health care consumers.

GOALS OF NATIONAL HEALTH INSURANCE

Part of the problem, we suspect, lies in the fact that we have not clearly articulated a national health policy which adequately and efficiently meets the health care needs of all our citizens, and particularly the low-income, minority, and rural area consumers. We suggest that such a policy must insure that each and every person, regardless of race, income, or geographic location, has high quality, comprehensive, and dignified medical, dental, and mental health care. I will not reiterate the myriad health care problems with which this Nation's citizens are confronted. Those problems have already been related to you many times. In that respect the record is clear.

However, I would like to share with you today some of the Urban League's ideas as to the fundamental components of any national health insurance bill designed to realistically address the most pressing health care needs of consumers and to simultaneously allow us to obtain the best health care possible for our per capita expenditures. In other words, what I would like to do is lay out some of the principles we strongly feel should be included in any health care legislation.

REFORM OF HEALTH CARE SYSTEM IS NEEDED

First of all, we hope that everyone has by now come to the conclusion that to secure effective legislation we must not continue to talk about further attempts to patch up the present health care system. Clearly, it has been demonstrated time and again that the present system is inequitable, too expensive, poorly regulated, and inaccessible to many persons.

Even those who are currently covered by some form of health insurance, lack balanced, comprehensive protection. We believe that if health care services are to be accessible to all, basic and sweeping reforms must be made. If we are to see the establishment of a national health program that will finally make the United States a world leader in health care, we believe a plan with clear goals must be devised—

one which deals with the real problems faced by our citizens. It must start from the premise that an unsophisticated mending job on the present system will probably prolong its failure at a higher cost.

On the issue of financing we generally support the position of the Health Security Council which was presented by Mr. Woodcock and his colleagues. As a matter of fact, Vernon Jordan, National Director of the Urban League, serves as vice chairman of that council.

FINANCING

We also feel that no amount of financial tinkering with private insurance schemes, deductibles, and State and Federal regulation can obscure the need for a single national health system trust fund operated by the Federal Government with funds from general revenues, contributory taxes, or a special surtax.

The system should be on a prepaid basis, stressing preventive medicine and outpatient care to reduce the need for hospitalization and its concomitant costs. We should also eliminate the piecework fee-for-service structure of health care which has resulted in placing decent health care beyond the financial grasp of millions of people.

We know that this subcommittee will carefully evaluate the cost of national health insurance and insure that the public is informed of the transfer of private spending to public spending. There may not be a substantial difference if efficiencies are mandated by a comprehensive national health insurance plan. If an effective and equitable plan results in a higher aggregate cost than that previously experienced, the difference will represent health care which has heretofore been denied to the poor and the near-poor. It is important that the total cost be spread as widely and as evenly as possible to minimize the impact on individuals.

To shrink back from an equitable and effective plan for false or unevaluated fiscal reasons will result in misery and in needless deaths, much of it resulting from the unfilled health needs of minorities which should be repudiated by any civilized society.

DELIVERY OF SERVICES

A national health program should provide for consumer participation in all of its functions and assure community control of facilities and programs that provide direct services. A major element of the service delivery component of a national health system should be equal access to quality health care for all. This means that two major principles must be followed:

First, poor people and minorities who have traditionally been denied decent health care, who have been isolated from quality care, whose contact with medical practitioners and clinics has led to fear and distrust, must be brought into the system through effective public health outreach programs that stress the dignity of the health services consumer, regardless of his station in life.

Second, the numbers of primary health practitioners must be increased. Most physicians today are in research, industry, hospital administration, or university positions or devote themselves to specialties, such as surgery, which remove them from the day-to-day practice of family health care. As a result we have gleaming new hospital centers that can perform the most sophisticated kinds of rare operations while a ghetto child can become asthmatic from neglect of a respiratory infection.

Consequently, we have a shortage of general practitioners as well as a geographic maldistribution of available medical practitioners. While some large urban areas and suburbs have an abundance of physicians, rural areas and ghetto neighborhoods are virtually abandoned by the medical profession, making proper health care inaccessible to many individuals.

The delivery of services is not solely dependent upon the numbers of doctors. The doctor shortage can be alleviated by creating new career structures for paraprofessionals. Medical paraprofessionals can perform some of the routine tasks now reserved for highly trained professionals and perform a key role in community health centers and health outreach programs.

Making health care accessible to all will mean more than insurance against catastrophic costs, or even coverage for preventive health care. It will also mean demystifying medicine, removing the elitist barriers of status and class, and making community health centers and doctors' offices places of hope and trust instead of places of fear and uncertainty.

EDUCATION AND TRAINING

On the issue of education and training, the keystone of a national medical education program should be free professional training open to any applicant in return for a 5-year service commitment upon professional certification. This would open the health professions, from doctors to social workers and nurses, to anyone capable of fulfilling the course of training, regardless of that individual's personal financial status. And it would create a large pool of health professionals committed to public health service and available for professional service in the areas now most in need of trained personnel.

Such a health education program would go far towards increasing the numbers of black doctors, now less than 2 percent of all doctors in the United States. It would also overcome the long heritage of discrimination and racial isolation of blacks within the health industry. It would be a giant step towards making decent health care available to all.

A national health program should also encourage—without income penalties—continuing training and formal education of health professionals. This is of special importance in providing incentives for physicians to constantly upgrade their skills and, consequently, the quality of health care which they provide.

EQUALITY OF TREATMENT

On the issue of equality of treatment, there should be a single class of health care for all. No plan enacted by this Congress should include one set of eligibility criteria and benefit levels for the poor and another for the affluent. No physician should be able to exact a higher price for his services than another physician other than what might be warranted by experience and measurable skill, and the cost of skill and experience should be spread through the insurance mechanism.

What should not be done directly ought not to be done indirectly. Any system of deductibles and coinsurance will inevitably lead to barriers against use and perpetuate a rich-poor dichotomy in the availability of good health care. If individual misuse of health services is a problem, such misuse will be identifiable under a national health program. Individuals who misuse the system must be counseled, and flagrant misuse can be curtailed by penalty.

CONCLUSION

In this testimony we have attempted to make a brief outline of what the league believes a national health program should encompass. It should be a national system devoted to providing quality health care for all of our people. It should be a rational system providing for national financing, cost controls, consumer influence, accessibility of services and expanded numbers and quality of health workers. It should not be a monolithic centralized program. There should be regional and community administration and, we assume, considerable subcontracting with existing public and private facilities.

It is a system that should improve the quality of health care in America. It is a system that provides a rational answer to the health problems our Nation faces. It is a system that puts first things first, health before profits, public interest before private gain, and the general welfare above the artificial barriers of race, class, and geographic location.

We believe that the system we have outlined should be basic to whatever national health program emerges from this Congress.

Thank you very much, Mr. Chairman.

Mr. Rostenkowski. Thank you.

Mr. Duncan will inquire.

Mr. Duncan. I have no questions, Mr. Chairman.

Mr. Rostenkowski. Mr. Corman will inquire.

Mr. Corman. Thank you, Mr. Chairman.

Mr. Brown, I certainly agree with your statement concerning some of the fundamental things we should do in whatever kind of a bill we report out. I am always amused at those who contend, first of all, that we have plenty of doctors but, second, we cannot have national health insurance because then we would have too many patients.

I think maybe there is something inconsistent with that conclusion. I appreciate your remarks.

Mr. Brown. Thank you, Mr. Corman.

Mr. Rostenkowski. Mr. Pike will inquire.

Mr. Pike. I want to also thank you for making a fine statement. I have no questions, Mr. Chairman.

Mr. Rostenskowski. Mr. Cotter will inquire.

Mr. Cotter. Just a brief question, thank you.

You suggest that we should have one national system of health insurance, am I correct?

Mr. Brown. That is correct, Mr. Cotter.

Mr. Cotter. Then over on page 7 you mentioned that it should not be a monolithic centralized program. It seems somewhat contradictory. Maybe you could elaborate a little bit on that.

Mr. Brown. I think when we talk about a national health insurance program, we are principally talking about the financing of that program and the general principles under which it is structured. We believe in the administration it is very important to have some kind of regional and local involvement. That is one of the reasons that we stress the need for community participation, particularly in local facilities.

We think that that is impossible without some degree of administrative responsibility at the local level.

Mr. COTTER. In other words, you would finance it on a national basis through payroll taxes or a surtax or whatever you feel is appropriate?

Mr. BROWN. Well——

Mr. COTTER. But it would be administered on a regional, State, or local basis? Will local units be able to set benefits?

Mr. BROWN. It would be administered on a Federal basis as well, but there would be regional and local involvement in that administration at that local level. In other words, there would be strong Federal guidelines, there would be strong Federal control, but there would be significant input at the regional and local level.

Mr. COTTER. What do you mean by input on the regional or local level?

Mr. BROWN. I mean that we have to find some way to work toward doing one of the things we had identified, that is, demystifying the whole health care system and the whole medical system. One of the problems now is that I think citizens find a lot of fear and apprehension about the system as it presently operates.

I think we need to find a way to get them more involved in it. I don't see how we can do that if we can insist on total Federal administration.

Therefore, we are trying to reach some kind of compromise which would allow for Federal control and Federal financing, but would also allow for citizen participation as we have attempted to do in a number of other programs such as revenue sharing and the Community Development Act and various other pieces of Federal legislation.

Mr. COTTER. Wouldn't that result in a great variation in type and degree of services provided?

Mr. BROWN. We would hope not, because we would cover that by guidelines which would be specific.

Mr. COTTER. You would have minimum guidelines at the Federal level, but the various local and regional offices might expand on them or——

Mr. BROWN. We would not provide the flexibility that would allow disparity in services rendered between one region and another.

Mr. COTTER. That is still difficult for me to comprehend.

Mr. BROWN. We would be glad to explore the issue further. I think there are a number of Federal programs under which this kind of system is working successfully, where there is strong Federal control but where we encourage citizen participation through working for administrators at the local level.

Mr. COTTER. Thank you very much.

Mr. ROSTENKOWSKI. Mrs. Keys will inquire.

Mrs. KEYS. Thank you, Mr. Chairman.

I appreciate your testimony very much, Mr. Brown. I agree with most of your basic concepts. I notice you are interested in and, I am sure, knowledgeable and concerned about the administrative problems and I have one question with regard to that.

Do you see universality of coverage as something that eases the administrative burden?

Mr. Brown. That is a very difficult question. My judgment would be that it would ease the administrative burden, but I think that that has not been proven with any definitude.

I think what we seek in urging universality is an equality of medical care we do not have now. I think that is our primary concern. We would, of course, be very blessed if the administrative burdens were lessened as well, but our primary goal is to be sure that health care services are provided equally throughout the country.

Mrs. Keys. It certainly would be true that there would not be the necessity of determining complex eligibilities and different tests that one must pass to have access to different programs in any kind of a comprehensive and universal program.

Mr. Brown. That is true and that would be a beneficial fallout effect, but not the primary purpose.

Mrs. Keys. Yes; thank you.

I would like to express Congressman Stark's words. He had to leave, but he appreciated your testimony very much.

Mr. Brown. Thank you very much.

Mr. Rostenkowski. Thank you, Mr. Brown.

Mr. Fulton? Thompson R. Fulton please.

Welcome to the committee. If you would, identify yourself and proceed with your testimony.

STATEMENT OF THOMPSON R. FULTON, PROFESSOR, UNIVERSITY OF MISSOURI SCHOOL OF SOCIAL WORK, ON BEHALF OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Professor Fulton. Mr. Chairman, and distinguished members of the committee, my name is Thompson R. Fulton. I am professor of social policy and social work practice, University of Missouri, School of Social Work, College of Public and University Services, Columbia, Mo.

With me today is Robert Cohen, senior staff associate of the National Association of Social Workers.

We prepared a written statement for the committee. In the time alloted, I will not be able to cover that, but I will state some highlights and would be glad if the committee would consider including that in the record.

We also have an analysis of five of the major bills which was prepared for our membership and we will make this available to the committee for your benefit.

Mr. Rostenkowski. It will be placed in the committee files.

Professor Fulton. If I may have a minute now for some old-fashioned personal testimony; quite a bit was said about the evils of bureaucracy, this morning, and I know they are there.

I am now ending a lifetime of service in two professions, one, the teaching profession; and the other, social work. I am combining them here.

I have worked for two local governments, a small rural school district when I was 17, and there is nothing more local than that, and the District of Columbia, when I was somewhat older.

I have worked for three States, West Virginia, Illinois, and Mississippi; and I have been employed by the Federal Government.

The point is, I would like to say that in all this period I can't really say that the bureaucracy or the Federal Government has impeded on my professional performance at any time.

I am here today in behalf of the National Association of Social Workers which is the largest professional organization of social workers in the world with 65,000 members and with chapters in each of the 50 States, the District of Columbia, Puerto Rico, Virgin Islands, and Europe.

We appreciate this opportunity to present our views on national health insurance.

Our interest derives not only from our wide experience in attempting to meet a broad range of human problems, but also from direct, substantial and growing involvement of social workers in the health care system.

As of 1970, the U.S. Census Bureau reported that more than 25,000 social workers were engaged in health and related programs. Current indications are that well over 30,000 social workers are now employed in health settings.

I shall discuss some general principles, but first I have two comments.

First, we urge that the national health policy for the United States rest on the well known philosophy of the World Health Organization which is:

> Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition.* * *

Such health care as a right can be a reality only when there are coordinated structures that provide essential care to all people. The traditional barriers to access must be systematically removed, including those caused by cost of services, improper distribution of facilities and personnel, or racial and sexual discrimination.

Second, we recognize that national health insurance, no matter how well designed, cannot of itself assure a high level of health throughout our country. Much ill health is traceable to poor housing, inadequate nutrition, low income, stress and strain, noise, atmospheric, water and food poisons, and a host of other conditions of modern living. These and other problems will have to be addressed in due course although we appreciate that they are beyond the purview of this committee. Among these problems is runaway inflation which must be controlled if a health system is to be established.

We present nine basic principles which in our judgment must be incorporated into our national health system.

1. The Federal Government role cannot be limited simply to mandating and subsidizing private insurance.
2. There must be no separate plan for the poor and/or medically needy.
3. There should be a nationwide pooling of health care risks.

4. A national health insurance system must be sufficiently comprehensive to insure a continuum of health care for every age group in the population.

5. Access to adequate health care must be regarded as a fundamental right of all Americans—a right which neither depends on the economic circumstances of those in need nor on the neighborhood, community or region of the country in which they happen to live.

6. There must be no deductibles and no coinsurance.

7. The funding mechanism for national health insurance must be progressive.

8. Provision must be made for monitoring the quality of care while insuring that costs are adequately contained; and

9. Provision must be made for developing human resources in the health field.

Now, I will elaborate on a few of these principles.

First, the Federal Government role. Governments are, by definition, concerned with the general welfare. They have both the right and the responsibility to establish improved arrangements in such vital matters as the people's health. They also have the right and responsibility to establish and monitor professions in the public interest, and/or set the conditions for their self regulation.

If the Federal Government is to put money, as it now does in substantial amounts, into the health care system, it must be responsible and accountable for health policy development, implementation, research, evaluation, regulation, financing, and monitoring under a clearly articulated plan.

With respect to separate plans, which are involved in a number of bills and not involved in others, we hold that there should be no separate plan for the poor and/or medically indigent. A separate plan would inevitably mean that a large group of Americans will be segregated into a degrading lower track of health care, and deemed inferior because they are unable to pay in full. Conventional wisdom still is that Government grants to poor individuals are prima facie evidence of worthlessness or worse, despite the corresponding social rationalization that Government grants and privileges extended to affluent individuals, ailing railroads, giant oil corporations, et cetera, are in the public interest. A separate health plan for low-income and high-risk persons amounts to segregation and discrimination on account of poverty.

Nationwide pooling of health care risks: There must be a nationwide pooling of health care risks to average out the costs and equalize the benefits for all families and individuals—and to reduce costs through economies of scale. Any plan which would permit the private sector to skim off the cream, that is, to insure the low-risk, high-profit sectors of the population, leaving the unable-to-pay and high-risk sectors to the Government and the taxpayers would be unjust and contrary to the public interest.

On the financing of health care, we have three comments to make.

First, we strongly recommend that health insurance on a national scale be financed on a prepaid basis without deductibles or copayments.

So-called cost-sharing devices would become a formidable barrier to access to millions of Americans who must live below the line of basic costs for food and shelter and clothing.

In our judgment, deductibles and copayments would result is underutilization of needed services, especially for the poor.

We are aware that it has been claimed by some that deductibles and copayments are necessary to prevent overutilization of services. From our experience, we submit that this is characteristic of a relatively small proportion of American citizens and that this tendency exists among all income classes, the affluent sector as well as the medically needy.

Cost sharing is not likely to prevent overutilization on the part of the applicant. It would, however, penalize a great majority of the poor who we submit are not inclined to overuse the health care system. There must be better ways to counteract any tendencies toward overutilization.

Second, the National Association of Social Workers is committed officially to the principle that taxation should be progressive. Its burden must be borne in relation to ability to pay. Whatever method of financing is finally chosen by the Congress for national health insurance, whatever mix of payroll taxes, general revenues, and so forth, we believe the sum total of this impact should be progressive.

To state the matter negatively, we are certain financing should not be regressive. And payroll taxes per se are now regressive especially for the poor.

If payroll taxes became part of the financing picture, a way can and should be found to exempt those citizens whose incomes are, say, 125 to 150 percent of the official poverty line.

Third, despite the allure of hidden subsidies, we hold that all financing of health insurance should be above board, out on the table. We will comment more fully on this shortly.

Quality assurance and cost control. We hold that public funds are a public trust and this fact demands that Federal and State funding must be accompanied by cost accounting and quality control. This is a public concern that cannot be delegated to the recipients of such funding. There can and should, however, be collaboration with the professions and industries involved and with consumers and consumer representatives.

It has been argued that incorporating these principles into a national health insurance plan would be prohibitively expensive. We believe this contention is grossly exaggerated and extends from concealment of present costs and misuse of data in estimating costs under the health insurance plan.

I have noted what I consider a costing game in which one proponent of a bill says, "My bill costs only $3 billion, but his bill costs $8 or $10 billion."

This, of course, represents one part of the cost which I suppose means that this is the new current additional cost to the Federal Government. But it fails to state other costs such as the cost to the States, the cost to consumers and the costs to taxpayers through hidden charges and so on.

The actual picture, of course, is that the total cost of personal health care under the proposed plans in 1974 ranged only about 10 percent, or less. The figures I have are that the administration plan would have cost $110 billion; the HIAA plan, $111 billion; the AMA program, $113 billion; the AHA program, $114 billion; and the health security bill would have cost $116 billion according to these statements by HEW.

At that time the projected cost, without a health bill, was about $103 billion. The range between the programs was, as I say, between $110 billion and $116 billion.

So that the total cost is something which needs to be brought out on to the table and presented.

A comment on hidden costs now. The tax subsidy to employers, employees, and other individuals is today a favorite device for governmental participation in health insurance financing.

No wonder it is favored because it gives the appearance of costing the Government nothing and it also continues indefinitely without the annual scrutiny which Congress gives to budgeting programs.

Tax subsidies, of course, whether in the form of deductions or tax credits are no less expenditures than if the Treasury collected the tax and returned it to the taxpayer. The amount of subsidies in these 1974 bills has been estimated by Davis—Karen Davis of the Brookings Institution—in a publication in 1975.

She estimated that four 1974 bills corresponding to four bills now before Congress would have had the following Federal tax subsidies:

The AMA bill would be $30; the AHA bill $9 billion; the HIAA bill, $8 billion; health security $1 billion.

I have rounded those off to the nearest tenth of $1 billion.

I do not have cost projections for the 1975 bills, but the hidden costs are still there.

We recommend strongly that each health insurance bill should present all of the costs, bring it all out on the table and make it available to the public.

Now, I have a brief comment on the role of social work in the program. We represent social workers here today and I am glad to tell you that we think social workers have proved themselves in a variety of settings of which we have several examples, but I will only mention two.

Medical social services in hospital settings have helped reduce the average length of stay. A study at the Mount Sinai Medical Center in New York City, found that those patients helped by social workers from the time of admission had hospital stays that were 10 days shorter on the average than patients who received it toward the end of their stay.

A demonstration project was conducted several years ago at the Massachusetts General Hospital to ascertain the value of social services in developing and coordinating nursing home placements for patients being discharged from the hospital. At the time the study was initiated, the average delay for patients leaving the hospital or transferred to a nursing home was almost 7 days. At the conclusion of the program, delay had been reduced to 2.4 days. On an annual basis savings of about 10,000 days of acute hospitalization resulted from utilizing the social services department.

There are other studies and empirical evidence bearing out the cost effectiveness which results from appropriate use of social services in hospitals and other health settings. However, the economic values should not be our sole meassure. The value in human terms is harder to assess, but no less vital.

In the mental health field, social workers practicing privately and in health settings offer their patients special skills such as those related to preventive therapy, cries, intervention, knowledgeable use of community resources and outreach services.

As of January 1970, more than 15,000 social workers were employed in psychiatric facilities throughout the country.

In examining staffing patterns in outpatient clincis at that time, one finds more social workers than psychologists, psychiatrists, and all other physicians combined. Statistics also show that social workers were spending more professional time in providing services at these facilities than the combined time of all psychologists and psychiatrists on duty.

Social workers are also the most significant group of health professionals providing services to the poor and minority groups and to people in areas of the country which are especially adversely affected by the maldistribution of health services.

Despite far reaching and significant roles played by social workers in the mental health field, none of the legislation now under consideration would provide a direct payment to social workers for services rendered. As such, this would adversely affect hundreds of thousands of people currently receiving individual and group counseling, psychotherapy and related mental health services provided by clinical social workers engaged in private practice and within agency settings. We urge this be addressed and we would be pleased to assist the Congress in developing the necessary legislative language at an appropriate time.

In conclusion, Mr. Chairman, few tasks facing this Congress are more demanding or more critical for the Nation's future than the design and enactment of comprehensive national health insurance. As we enter our third century of independence, you have an opportunity of expanding the dimension of freedom for the people of this country. You can help enact a health bill of rights for all Americans through legislation which embodies the principles which we have discussed today. In so doing you can help to free millions of our citizens who are currently shackled by medical expenses, confined and debilitated by illness and subject to the myriad inadequacies of our present health care delivery system.

Mr. Chairman and members of this committee, thank you for offering us this opportunity to present our views on national health insurance.

[The prepared statement follows:]

STATEMENT OF THOMPSON R. FULTON, PROFESSOR, UNIVERSITY OF MISSOURI SCHOOL OF SOCIAL WORK, ON BEHALF OF THE NATIONAL ASOCIATION OF SOCIAL WRKERS

Mr. Chairman and distinguished members of the committee, my name is Thompson R. Fulton. I am Professor in Social Policy and Social Work Practice at the University of Missouri School of Social Work, College of Public and Community Services, Columbia, Missouri. I am here on behalf of the National Association of Social Workers, the largest organization of professional Social Workers in the world. We represent 65,000 members in chapters in each of the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands and Europe. We appreciate the opportunity to present our views on National Health Insurance.

Our interest derives not only from our wide experience in attempting to meet a broad range of human problems, but from the direct, substantial, and growing involvement of Social Workers in the health care system. As of 1970 the U.S. Census Bureau reported that more than 25,000 Social Workers were engaged in health and related programs. This represented a four-fold increase since 1950.

(U.S. Department of Labor, B.L.S. *Social Workers in 1950 A Report on the Study of Salaries and Working Conditions in Social Work.* N.Y. AASW, Inc. 1950). By 1972 the total had risen to 29,500 according to Public Health Service estimates. Current indications are that well over 30,000 Social Workers are now employed in health settings.

We are well aware that in the area of health, problems range beyond the familiar and much documented issues of costly and inadequate medical and hospital care. There is, as I am sure the members of this Committee recognize, a need to improve our entire health care system. This system embraces all aspects of prevention, rehabilitation and health maintenance. It is complex. Along with the medical dimensions, such issues as utilization of existing community agencies and resources, continuity of services, personal and psychological aspects of health, community maintenance, outreach efforts and much more need to be addressed. Indeed the social component of health care cannot be too strongly emphasized. I will expand on this theme later in my testimony. At this point however, I would like to turn my attention to a number of principles which our Association believes Congress must incorporate in any National Health Insurance plan which seeks to address the critical health needs of our Nation.

COMMENT

We urge that national health policy for the United States rest on the well known philosophy of the World Health Organization:

"Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition ... It is a state of complete physical, mental and social well-being and not merely the absence of infirmity."

Health care as a right can be a reality only when there are coordinated structures that provide essential care to all people. The traditional barriers to access must be systematically removed, including those caused by cost of services, improper distribution of facilities and personnel, or racial and sexual discrimination. Present mechanisms must be reorganized to fulfill the commitment to health as a right by providing quality, dignified health care for all people.

We recognize that National Health Insurance, no matter how well designed, cannot of itself assure a high level of health throughout our country. Much ill-health is traceable to poor housing. inadequate nutrition, low income, stress and strain, noise; atmospheric, water and food poisons; and a host of other conditions of modern living. These and other problems will have to be addressed in due course although we appreciate that they are beyond the purview of this Committee. However, a boldly conceived National Health Insurance plan would be a major stride toward overcoming a substantial portion of our Nation's health problems.

Such a plan must incorporate the following:

BASIC PRINCIPLES

1. The Federal government's role cannot simply be limited to mandating and subsidizing private insurance.
2. There must be no separate plan for the "poor" and/or medically needy.
3. There must be a nationwide pooling of health care risks.
4. A national health insurance system must be sufficiently comprehensive to ensure a continuum of health care for every age group in the population.
5. Access to adequate health care must be regarded as a fundamental right of all Americans—a right which neither depends on the economic circumstances of those in need nor on the neighborhood, community or region of the country in which one happens to live.
6. There must be no deductibles and no coinsurance.
7. The funding mechanism for National Health Insurance must be progressive.
8. Provision must be made for monitoring the quality of care while ensuring that costs are adequately contained.
9. Provision must be made for developing human resources in the health field.

FEDERAL GOVERNMENT ROLE

Governments are by definition concerned with the general welfare. They have both the right and responsibility to establish improved arrangements in such vital matters as the people's health. They also have the right and responsibility to establish and monitor professions in the public interest, and/or set the conditions for their self-regulation.

If the Federal government is to put money into the health care system, it must be responsible and accountable for health policy development, implementation, research, evaluation, regulation, financing, and monitoring under a clearly articulated plan.

NO SEPARATE PLAN FOR POOR

There must be no separate plan for the "poor" and/or "medically indigent." A separate plan would inevitably mean that a large group of Americans will be segregated into a degrading "lower" track of health care, and deemed inferior because they are unable to pay in full. The conventional wisdom still is that government grants to poor individuals are prima facie evidence of worthlessness or worse, despite the corresponding social rationalization that government grants and privileges extended to affluent individuals, ailing railroads, giant oil corporations, etc., are "in the public interest." A separate health plan for low-income and high-risk persons amounts to segregation and discrimination on account of poverty.

NATIONWIDE POOLING OF HEALTH CARE RISKS

There must be a nationwide pooling of health care risks to average out the costs and equalize the benefits for all families and individuals—and to reduce costs through economies of scale. Any plan which would permit the private sector to skim off the cream, i.e., to insure the low-risk, high-profit sectors of the population, leaving the unable-to-pay and high-risk sectors to the government and the taxpayers would be unjust and contrary to the public interest.

COMPREHENSIVE HEALTH CARE

A national health insurance system must be sufficiently broad to cover preventive and diagnostic services; in-and-out-patient care and treatment, acute and chronic illness; mental health, medical and dental care; social services, community health supports and other ancillary services needed to ensure that a full spectrum of personal health care services is available to all.

In the absence of a comprehensive range of services, millions of Americans will still be deprived of access to essential components of health care. Moreover, failure to obtain early diagnostic and preventive services ultimately adds to the cost of in-patient care and other treatment which subsequently becomes necessary Lack of homemaker services, home health aides and other post hospital supports often precludes the possibility of care in the home especially in the case of elderly and/or isolated patients.

Far too often we are forced to rely on more expensive types of care—e.g., professional rather than paraprofessional, institutional rather than community based—simply because a wide range of services which would allow for more appropriate selection, is not available or is not properly utilized. A health insurance system which does not include adequate supportive services not only will fail to meet the needs of the medically indigent but also will add to costs which might otherwise be eliminated or significantly reduced.

ACCESS

A national health insurance system must ensure that access to care does not hinge on the financial circumstances of the individual and that differences of economic, employment, age, or "medical risk" status do not result in differential treatment. As social workers, we can attest o tthe validity of the now familiar observation, "programs designed for the poor generally turn out to be poor programs." We have seen the truth of this axiom in such diverse areas as job training, low-income housing, child welfare services, nursing home care and the like. Inadequate funding, short range notions of cost saving and antipathy toward those in our society who lack financial resources, has been chiefly responsible.

All too often, through tracking systems, through separate services, differential delivery mechanisms and dual standards, those in our population who start out most disadvantaged are the very ones who ultimately benefit least from Federal and state aid programs. We are concerned that this pattern not be further extended in a National Health Insurance program.

FINANCING NATIONAL HEALTH INSURANCE

We have three comments on financing. First, we strongly recommend that National Health Insurance be financed on a wholly-prepaid basis. There should be no deductibles, no co-payments. These so-called "cost-sharing" devices would become a formidable barrier to access to needed health care, for millions of Americans who must live on incomes below that necessary for the basic costs of food, shelter, clothing. In our judgment, deductibles and co-payments would, if made part of National Health Insurance, result in under-utilization of needed services, especially for the poor.

We are aware that it has been claimed by some, that deductibles and co-payments are necessary to prevent over-utilization of services. From our experience, we submit that the tendency to over use health services is characteristic of a relatively small proportion of American citizens, but that this tendency exists among all income classes—the affluent sector as well as the medically-needy. Cost sharing is not likely to prevent over-utilization on the part of the affluent; and it would penalize the great majority of the poor who, we submit, are not inclined to over use health care services. There are better ways to reduce any tendencies toward over-utilization. For instance the physician's judgment as to whether care is required is well accepted today, as it was in generations past; and physicians today also have access to facilitating and supportive services of social workers, nurses, vocational rehabilitation counselors, et al.

We point to one important aspect of over-utilization which may well be investigated by the Congress—namely, a growing body of allegation of over-utilization which is within the control of providers—e.g., unnecessary operations to provide learning experiences for students; extended hospital stays which help balance the budgets of hospitals in areas where facilities have been over-built; and the recently revealed information about payments to physicians—e.g., that it is possible for a single physician to be paid over $400,000 in a year for services to Medicare and Medicaid patients.

Secondly, the National Association of Social Workers is committed officially to the principle that taxation should be progressive, its burden to be borne in relation to ability to pay. Whatever method of financing is finally chosen by the Congress for National Health Insurance, whatever mix of payroll taxes, general revenues, etc.—we believe that the sum total of its impact should be progressive. To state the matter negatively we are certain that financing should not be *regressive*, as payroll taxes are, now regressive. If payroll taxes become part of the financing picture, a way can and should be found to exempt or rebate those citizens whose income is, say under 125–150% of the official poverty line. We as an Association are committed to work toward a tax policy that, below a specified income floor, no family or individual would pay any tax, unless a guaranteed income becomes a reality and includes taxes paid.

Thirdly, despite the allure of hidden subsidies, we hold that *all* financing of National Health Insurance should be above board, out on the table. We will comment on this more fully, soon.

QUALITY ASSURANCE/COST CONTROL

Public funds are a public trust, and this fact demands that Federal and State funding must be accompanied by cost accounting and quality control. This is a public concern that cannot be delegated to the recipients of such funding. There can and should however, be collaboration with the professions and industries involved and with consumers and consumer representatives.

RESOURCE DEVELOPMENT

Measures must be taken to vastly increase the facilities and programs for training physicians, dentists, nurses, social workers and other types of allied health personnel. Special emphasis should be placed on development of minority group manpower. Creative redeployment and utilization of the various professional and allied specializations must be carried out in order to make the most effective use of the potential contribution of each, working as an interdisciplinary team.

It has been argued that incorporating the above principles into a National Health Insurance plan would be prohibitively expensive. We believe this contention is grossly exaggerated and stems from concealment of present costs and misleading use of data in estimating costs under National Health Insurance.

THE COSTING GAME

We note what appears to be a kind of gamesmanship about the costs of various individual proposals for National Health Insurance. The game is played by some public officials and perhaps by some official sponsors and some organizations sponsoring individual bills. The game is to give out selected figures suggesting or stating that the favored bill would cost less than its competitors. The assumption is that the public, having great faith in statistics, believes that figures won't lie.

One ploy is that "our" bill would cost only three billion dollars whereas a competing bill would cost, say, 8 billion dollars. Another ploy is to assert as was done on the floor of the House when one of the current bills was introduced that private insurance is today providing coverage "at no cost to the government" (*Cong. Record*, April 22, 1975, p. H–3118).

The first "ploy" states estimates of the *current additional budgeted* cost to the Federal Government, but fails to state other costs, e.g. to the State, to consumers via cost sharing, to taxpayers via hidden costs, and so on. It also fails to compare the bills in terms of increased access to health services. In contrast, the available estimates of total 1975 personal health cost under plans proposed in the 93rd Congress (and roughly comparable bills before this Committee) show a range of some five percent: Administration plan $110 billion; HIAA, $111 billion; AMA $113 billion; AHA $114 billion; Health Security $116 billion. The total cost as is, without any new National Health Insurance plan was projected as $103 billion (Source: USDHEW, Estimated Health Expenditures under Selected National Health Insurance Bills—A Report to the Congress, July 1974).

HIDDEN COSTS

In regard to the other "ploy" suggested above, something is missing if it is said that private health insurance today operates at no cost to the government.

The tax subsidy to employers and/or employees and to other individuals, in return for purchasing Health Insurance policies, is today a favorite device for governmental participation in Health Insurance financing. No wonder it is favored, because it gives the appearance of costing the government nothing, and it also continues indefinitely without the annual scrutiny which Congress gives to budgeted expenditures. Tax subsidies, whether in the form of deductions, or tax credits, are no less an expenditure than if the Treasury collected the tax, then made an equivalent payment back to the taxpayer. For this reason the Congress is now beginning to estimate and report "tax expenditures" along with the budget document. The estimated total of subsidies ("tax expenditures") is, for the 1976 budget, $72 billion—a sum equivalent to nearly the entire cost of personal health services, or an amount adding 26% to the actual Budget. For health care, Federal tax subsidies amounted to $6 billion last year.

Important estimates of the cost of subsidies in 1974 National Health Insurance bills have just been made available by Davis (Karen Davis, National Health Insurance—Benefits, Cost and Consequences, The Brookings Institution, August 1975). For four bills corresponding to four 1975 bills, the total Federal tax subsidies would have been:

	Billions
No national health insurance	$6.1
AMA	29.9
AHA	8.9
HIAA	7.9
Health security	1.1

Unfortunately, cost projections for 1975 (94th Congress) bills are not available at this time, but hidden costs are still there, in some of the 1975 bills.

We hold that all National Health Insurance plans should show all costs aboveboard, none hidden. There should be no tax deductions, tax credits or other subsidies; and all existing subsidies should be rescinded, or phased out over a reasonable period of time. This would be consonant with National Association of Social Workers' Policy Statement on Taxation (See NASW News, July 1975). Until the demise of subsidies, their cost should be identified clearly in all cost estimates.

SOCIAL WORK ROLES

To attain maximum cost benefits, appropriate utilization of services, effective coordination of the efforts of agency and individual health service providers, and continuity of care, must be prime concerns. In this respect the services of trained social workers have proven themselves in a variety of settings. Thus for example:

> In 1972 a pilot project was undertaken at the Denver General Hospital to test fiscal savings following changes in the use by 30 patients of the emergency room after social work intervention. The patients had been identified by the emergency room staff (mainly nurses) on the basis of "excessively high utilization of services" during the six months prior to social work contact. Following intervention, savings, stemming from reduced number of ambulance runs and fewer repeat visits to emergency service, amounted to nearly $2,800. After subtracting cost of the social worker's time, net savings total $1,800—approximately $60 per patient. Additional savings were effected as a result of a significantly higher rate of kept medical appointments. Prior to intervention, the test group of patients missed 50% of follow-up clinic visits; after intervention only 28% of such visits were missed.
>
> A related study involved Social Workers in the Neighborhood Health Program. Following social service intervention the number of physician and treatment room visits for a group of 26 patients dropped from 255 to 53 during a comparable six month time span, a decrease of almost 80%. The studies cited are admittedly of limited scale. It would appear, however, that if savings of this sort could be replicated in the thousands of similar settings across the country, the cost savings could in fact be substantial.
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> A more recent report, "Cost Containment As a Result of Social Services in a Nursing Home," comes from Atlanta. Labe Mell, President of the Georgia Nursing Home Association, and Administrator of the Moody Nursing Home cited a reduction in operating expenses of .93 per patient day from September 1972 to September 1973 following addition of a full time person to the Social Services Department. Rates, staffing and other significant factors had remained constant. "What really changed," according to Mr. Mell, "was patient/staff/family attitude as a result of our new Social Service emphasis.
>
> Medical social services in hospital settings have helped to reduce the average length of stay. A study at the Mt. Sinai Medical Center in New York City found that those patients who were helped by social workers from the time of admission had hospital stays that were ten days shorter on the average than those patients in the traditional system who were referred to social service late in their hospitalization by physicians.
>
> A demonstration project was conducted several years ago at the Massachusetts General Hospital to ascertain the value of social services in development and coordination of nursing home placements for patients being discharged from the hospital. At the time the study was initiated the average delay for patients leaving the hospital for transfer to a nursing home facility was 6.8 days. At the conclusion of the program average delay had been reduced to 2.4 days. On an annual basis, savings of approximately 10,000 days of acute hospitalization resulted from utilization of the Social Service Department in discharge planning.

Other studies and empirical evidence bear out the cost effectiveness which results from appropriate use of social services in hospital and other medical and health settings. However the demonstrated economic value which accrues from proper utilization of Social Workers in health facilities should not be our sole measure. The value to patients and families in human terms is harder to assess, but no less vital. For instance, Social Work counseling, prior to and following surgery, lessens anxiety and facilitates utilization of nursing and medical care. Counseling by qualified Social Workers promotes adjustment by patients and their families to the impact of trauma and serious disease, and to the fear, depression and despair wrought by terminal illness. Improved societal adjustment, enhanced personal well being and increased capacity to deal with illness in all its ramifications are but some of the hallmarks of skilled Social Work intervention in the health field.

Recognizing the necessity of dealing with the social component of health, Congress took a significant step toward building a more comprehensive health care system when it enacted the Health Maintenance Organization Act of 1973. HMO's will undoubtedly be instrumental in providing better quality care for patients and in reducing the overall costs of a National Health Insurance program. The legislation recognizes the value of social work and has mandated inclusion of medical social services in HMO's. Also, the Joint Commission on the Accreditation of Hospitals has required community and other hospitals to have social service departments. It would certainly be both inconsistent and unwise if a National Health Insurance system were to fail to include Social Work services within the benefit package, especially in light of the heavy reliance which is likely to be placed on use of HMO's and on community hospitals in the future.

MENTAL HEALTH SERVICES

Mental health services, including inpatient and outpatient therapy, partial hospitalization and after care represent a major component of the comprehensive system of health care which we envision. With current emphasis on deinstitutionalization and the corresponding decline in psychiatric inpatient care, the overwhelming number of mental health patients are living in communities where a wide range of therapeutic, rehabilitative and supportive services must be accessible both for those who have been hospitalized and for those whose hospitalization we wish to prevent.

THE CONTRIBUTION OF SOCIAL WORKERS IN THE FIELD OF MENTAL HEALTH

In the field of mental health, social workers represent one of the three core professions providing private and public therapeutic services. In addition to generic therapeutic skills, Social Workers practicing in mental health settings as well as privately offer their patients special skills, such as those related to preventive therapy, crisis intervention, the knowledgeable use of community resources to meet special needs, and outreach services of particular value to the homebound, the disadvantaged and the hard-to-reach patient.

As of January 1970, more than 15,000 social workers were employed in psychiatric facilities around the country. In examining staffing patterns in free-standing outpatient psychiatric clinics in January 1970, one finds more social workers (5,461) than any other profession; and, more full-time social workers than psychologists, psychiatrists and all other physicians combined: 3,014 social workers to a total of 2,042 for the other three professional categories.

In a comparison of the distribution of staff time, by discipline, in selected inpatient psychiatric facilities and in free-standing outpatient psychiatric clinics, statistics show that social workers again were spending more professional time in providing service at these facilities than the combined time of all psychologists and psychiatrists on duty.

Social Workers are also the most significant group of health professionals providing services to the poor, to minority groups and to people in areas of the country which are especially adversely affected by the maldistribution of mental health services.

MULTIPLE ENTRY

A truly adequate and comprehensive system of National Health Insurance must provide a full range of mental health services available and accessible to all segments of our population. Moreover it must afford consumers greater opportunity to enter the system than now exists. Recognition of the social component of health care carries with it the notion of a multi-faceted system and correspondingly the need for providing multiple points of entry. No longer must any one group, one profession or one industry be permitted to control the avenues, the bridges and the gates to that system, nor unilaterally determine the price and conditions for admission.

Moreover, the concept of a many-sided, multi-tiered system requires that recognition be accorded to all key health professionals who provide services within that system whether under agency aegis or as independent practitioners. This is particularly true with respect to mental health care in which several disciplines provide services often closely related and at times totally congruent. Yet for the patient, access to care is frequently restricted, expensive and marked by delay.

Despite the far reaching and significant role of Social Workers in the mental health field, none of the legislation now under consideration would provide for direct payment to Social Workers for services rendered. As such, this would adversely affect hundreds of thousands of people currently receiving individual and group counseling, psychotherapy and related mental health services provided by clinical Social Workers engaged in private practice and within agency settings. We urge that this shortcoming be addressed, and we would be pleased to assist Congress in developing the necessary legislative language at the appropriate time.

CONCLUSION

Few tasks facing this Congress are more demanding or more critical for the Nation's future than the design and enactment of comprehensive National Health Insurance. As we enter our 3rd century of independence you have an opportunity of expanding the dimension of freedom for the people of this country. You can help enact a "Health Bill of Rights" for all Americans through legislation which embodies the principles which we have discussed today. In so doing you can help to free millions of our citizens who are currently shackled by medical expenses, confined and debilitated by illness and subject to the myriad inadequacies of our present health care delivery system.

Mr. Chairman and members of this committee, thank you for offering us this opportunity to present our views on National Health Insurance.

Mr. ROSTENKOWSKI. Thank you, Mr. Fulton.

Are there any questions of the witness?

Mr. Corman?

Mr. CORMAN. Mr. Fulton, I would like to say that I think one of the more serious mistakes we made in the SSI program was that we thought we could find an inexpensive way to take care of the aged, blind, and disabled, and they did not need social workers. That is a big chunk of what is wrong with that program. I appreciate your pointing out to us that when we move into the national health insurance program, as we will sooner or later, that there will be a critical role for the social worker if that program is going to work. We thought we could just send a check each month to the aged, the blind, and disabled. But that is inadequate, and that is a major part of the reason for the SSI failures.

I think of all the professions that you might have devoted your life to, it must make you proud at this stage of your life for having chosen what you did.

Thank you.

Mr. ROSTENKOWSKI. Mr. Keys?

Mr. KEYS. Yes; I would just like to thank Mr. Fulton and ask you to carry back to Columbia, Mo., my greetings to all my friends there; I lived there for 2 years, and was affiliated with the university. So, I would appreciate that. Thank you so much for this excellent testimony.

Also thank you for the little word of enlightenment you shared with us in the begining about the fact that in the various experiences you had in your professional lifetime, the big, bad ogre of bureaucracy had not severely limited your professional success or your capacity to make a contribution. I think we are living in a day in which bureaucracy has assumed the terror of the "Red under every bed" during the McCarthy era. It sometimes waylays us from getting to the problems we are facing and doing something about them.

Thank you very much.

Mr. ROSTENKOWSKI. Thank you, Mr. Fulton.

Mr. Milton Weidler?

STATEMENT OF BEVERLY WARE, PRESIDENT, SOCIETY FOR PUBLIC HEALTH EDUCATION, INC., AS PRESENTED BY MILTON J. WEIDLER, PRESIDENT, NATIONAL CAPITAL AREA CHAPTER OF THE SOCIETY FOR PUBLIC HEALTH EDUCATION

Mr. Rostenkowski. Welcome, Mr. Weidler, to the committee. If you would identify yourself and your organization, you may proceed with your testimony.

Mr. Weidler. Thank you, Mr. Chairman.

Mr. Chairman, ladies and gentlemen, I am Milton J. Weidler, president of the National Capital Area Chapter of the Society for Public Health Education. My testimony is in behalf of the Society for Public Health Education as submitted by Beverly Ware, our president, who was unable to attend this morning.

RECOMMENDATIONS

The most important impact of the practice of health education on any national health insurance program will be to influence the understanding, and subsequently the behavior, of people toward utilization of the health care delivery systems.

Let us consider the essentials of providing a comprehensive educational effort in any system through a national health insurance program.

(1) There needs to be a massive amount of education directed toward people in order for them to know and understand the system. Such efforts must by necessity include both information giving through the mass media, as well as individual face-to-face, small group and community education programs.

Any national insurance program must have provisions for education of the public on the dimensions of the program including benefits, costs, provided services, and sites of delivery.

(2) There needs to be developed specific educational programs which will educate people how to utilize all parts of the health care system most effectively.

In its broadest sense this kind of approach will include education of the users of service so that they are able to understand where to go for a particular service as indicated. Basic to being able to use the system most effectively, however, is that the person know what is provided.

Special education efforts must be mandated in all health service delivery systems to acquaint users with the provisions and how they are implemented.

Any national health insurance program, therefore, must provide comprehensive education of the users of services on appropriate use of the system.

(3) There needs to be developed educational programs which will promote the maintenance of health rather than concentrate on treating symptoms of ill-health. While on the one hand, people must be able to utilize health care services effectively and efficiently, there must be concerted efforts on the part of those rendering health services toward health promotion and prevention, including consumer self-help programs and community outreach programs.

(4) There needs to be included, as part of the treatment of any person, education directed toward understanding of the condition.

More important, there must be educational approach toward treatment activities which will encourage and influence persons to assume responsibility for recommended followup and maintenance.

Basic to such endeavor is the training of health personnel on all levels—physicians, dentists, nurses, pharmacists, et cetera—as well as educators. Any national health insurance program therefore must have provisions for education of health personnel, especially emphasizing patient education. Education of the patient must be an integral part of all patient care, specifically educational efforts to help the user understand the nature of the problem and to achieve appropriate self-sufficiency in followup and future care.

(5) There needs to be mechanisms developed so that the users of services participate in the planning and subsequent development of services. It is no foolish truism that says "if you want someone to be part of the program, you must involve them and make them participants in its development."

Any national health insurance program must have provisions for user involvement in the planning and development of services.

Finally, the educational activities described above must be directed by professionally trained health educators.

ADDITIONAL REMARKS CONCERNING RECOMMENDATIONS

The Society for Public Health Education is a national professional association of nearly 1,200 members, the large majority of whom spend full time in the professional practice of health education.

The society has testified previously on October 29, 1971, before the Ways and Means Committee concerning its support for a national, universal health insurance program giving special emphasis to the need for health education as a specific, funded benefit. You can see that in our appendix A, Mr. Chairman.

Since that time, there has been a series of events that have occurred with respect to health education, the results of which have reinforced the need for additional health education programs especially within any health care delivery system.

The President's Committee on Health Education, in its final report, indicated the need to have as a focus for consumer health education that individuals would "utilize health resources and services and environmental support, with optimal efficiency and economy."[1]

Two, the task force on consumer health education, established by the American College of Preventive Medicine and the Fogarty International Center, in its strategy recommendations listed as the first priority the requirement that "as a condition of Federal, State, and local funding that all hospitals, HMO's, neighborhood health centers, and other community health facilities—both public and private—provide qualified consumer health education as an integral part of their service responsibilities to their individual users and to the community as a whole."

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[1] The report of the President's Committee on Health Education, Department of Health, Education, and Welfare, Health Services and Mental Health Administration, p. 13.

Further, the second strategy was to "require or encourage all third-party payors—public and private—to reimburse providers for the net costs of patient education."

Three, on July 30, 1975, Senate bill 1466, the National Consumer Health Education and Promotion Act of 1975, passed the Senate.

This legislation established in the Department of Health, Education, and Welfare, an Office of Consumer Health Education and Promotion which would—

> Engage in research in health education and promotion, develop community health education programs, stimulate, and coordinate communications in health education, and overview and coordinate Federal programs.

Four, a National Center for Health Education has been very recently created whose functions will include consensus building and policy determination, national strategy design, health education advocacy, data base development, evaluation and demonstration, and technical assistance in providing leadership and direction to a comprehensive national health education program on the prevention of disease, disability, premature death, and undesirable and unnecessary health problems.

Five, a Bureau of Health Education within the Department of Health, Education, and Welfare was structured and placed in Atlanta, Ga., and has provided a very needed Federal focus for health education.

Six, the recently passed legislation, Public Law 93–641, indicates as one of the 10 priority areas of the bill the need for the planning and development of health education programs particularly directed toward personal health care.

All of these events confirm the swelling interest and concern with health education as an essential aspect of health promotion, maintenance, and care.

The recommendations presented are directed toward insuring that there be comprehensive health education programs within any national health insurance, however it is structured. Our concern is with the health education component that must be contained within any insurance program and not on any particular insurance mechanisms.

Thank you very much.

[Attachment to the prepared statement follows:]

APPENDIX A

SUMMARY AND RECOMMENDATIONS OF THE SOCIETY FOR PUBLIC HEALTH EDUCATION, INC., SAN FRANCISCO, CALIF.

SUMMARY

The Society for Public Health Education, a national professional association, presents a position in favor of a national, universal health insurance program. Within the context of general support for such a program, the Society gives special emphasis to the need for health education as a specific, funded benefit.

A rationale for educational benefits is given, including the expected contribution of such benefits to the reduction of human factors failures in the health delivery system. Examples are given as suggestive of a broad potential for health education in national health insurance. Specific criteria for educational components are listed and recommendations are made for implementing development and proving of appropriate health education techniques.

The Society for Public Health Education states its availability to advise in technical design of educational components for inclusion in a benefits package.

RECOMMENDATIONS

The Society for Public Health Education recommends:

1. Approval of national health insurance, universal in coverage and eligibility and providing preventive, curative and rehabilitative benefits.
2. Inclusion of education of the consumer, patient and provider as a specified, funded, benefit.
3. Constitution of an office of health education in the US Department of Health, Education and Welfare.

TESTIMONY OF LOWELL S. LEVIN, ED.D., M.P.H. FOR THE SOCIETY FOR PUBLIC HEALTH EDUCATION, INC.

Mr. Chairman, ladies and gentlemen, I am Lowell S. Levin, Associate Professor of Public Health, Department of Epidemiology and Public Health, Yale University School of Medicine, New Haven, Connecticut. My testimony today is on behalf of the Society for Public Health Education, Incorporated, with headquarters in San Francisco.

The Society for Public Health Education is a national association of 680 individuals with professional interests and expertise in promoting, through education, better health practices both by the consumers of health care and by those who provide health care. In addition to setting standards for the education and training of public and community health educators and developing continuing education for practitioners of health education, the Society publishes a professional journal, *Health Education Monographs*, and *Abstracts* of relevant journals.

The Society through its national committees and its thirteen regional chapters reaching from Boston to North Carolina to Hawaii, works closely with and through governmental and voluntary health groups, community health groups and health services programs to enhance the effectiveness of preventive and curative health efforts.

POSITION ON NATIONAL HEALTH INSURANCE

Those of us in public health who have worked to achieve more efficient and effective utilization of health resources cannot escape realizing the overwhelming negative impact of the financial barrier to health care. All levels of society and all age groups are affected. We are faced with the fact that the often devastating costs of medical care are not calculated to encourage an individual's use of the care system in ways which will contribute to early detection and the lessening of disability. Indeed, the reverse is true. Our present limited sickness-payment system of financing encourages episodic, crisis medicine, with gaping holes in comprehensiveness and continuity.

Frankly, we believe that we have gone just about as far as we can go in encouraging preventive health behavior on the part of consumers and of providers until we have a nationwide health insurance coverage which takes the money factor out of the consumer's decision to seek or the provider's decision to deliver health care.

The Society for Public Health Education through a unanimous vote of its membership at the annual meeting in Minneapolis earlier this month has gone on record as being firmly and strongly in support of a national health insurance program with universality of eligibility and coverage, with no restrictions as to age, sex, citizenship, residence, ethnic group, income or employment status or the nature of the health need. We are prepared to support an insurance plan which embodies this characteristic of universality and covers all manner of recognized medical services for prevention, cure and rehabilitation; provides and maintains standards of quality; involves consumers together with providers in the process of planning and evaluating effectiveness; and ensures public knowledge of program operations.

It is these essential criteria upon which our recommendations for enhancing the effectiveness of *any* national health insurance program rest. We are convinced that the adoption of these criteria will make it possible to operate free of constraints which erode our ability to have a significant impact on matters of efficient and effective utilization. Any approach of national health insurance that is exclusively geared to removing the economic barriers to care and omits these above design criteria loses any leverage for improving the quality of use. The United States must adopt a plan which gives a fighting chance to prevent disease and illness, reduce inordinate dependence on health resources, develop individual responsibility for health maintenance, and tailor care to the needs and expectations of the consumer and of the provider.

Beyond removal of economic barriers the human factor is the central issue. Patterns of consumer and provider behavior are firmly established. Change in values and attitudes regarding the use or the provision of health resources will require a mandate and a purposeful set of plans, benefits and sanctions for education of all involved.

EXAMPLES OF HEALTH EDUCATION IN HEALTH CARE

The members of the Society for Public Health Education are particularly experienced in dealing with the human factors aspect of health—that is, in dealing with motivation, behavior, learning and communication. We are interested, for example, in solving such problems as patient delay in seeking medical care, unnecessary re-admission to hospital for the same condition, patient inability to use health services appropriately, breakdowns in communication and motivation resulting in patient failure to follow orders or to take medications, unnecessary delay in patient recovery, and the like.

Let us take a look at some examples of the *need* for health education to reduce costs and preserve health, and some examples of actual *impact* of health education on utilization of health care.

In 1969 the Department of Health, Education and Welfare Task Force on Health Manpower pointed out that practically all deaths from cervical cancers could be prevented, and hospital and medical costs for women with this condition be reduced by half, that is, reduced from $2,000 to $1,000 per patient, *if* women had regular Pap smear tests. Although this knowledge has been available since 1928, cervical cancer continues to kill 8,300 women annually and to require nearly a million days of hospital care each year. Only one in four women 20 years of age or over has a Pap smear each year.

A second example from the same DHEW report: About 95 percent of recurrences of rheumatic fever, along with resulting heart damage and deaths, could be prevented through preventive, regular doses of penicillin or other antibiotic. Although we have known how to prevent recurrences of rheumatic fever since 1943, rheumatic fever and rheumatic heart disease continue to kill nearly 18,000 persons annually and require more than a million days of hospital care each year. Only one in twenty persons who have had rheumatic fever receives medication.

Who needs health education in such situations? Professionals do in terms of appropriate screening and prescribing; patients do in terms of motivation and understanding; families do in terms of support and reinforcement; and those in control of health planning and financing do in terms of making service available and acceptable.

A number of projects have been reported which show the impact of education on the hospitalization of patients with congestive heart failure. In Dade County, Florida, a study was made of two groups of patients with congestive heart failure. After hospital discharge one group received nursing visits with a strong educational component: the other group did not. The group receiving education required substantially fewer days of hospitalization (332 days) than the group receiving no special educational service (521 days).

In Loma Linda, California, patients in the study group which received intensive "educational care", as it was termed, were far less likely to have a return to the hospital than a comparison group which did not receive educational sive "educational care", as it was termed, were far less likely to have to return one year period. Only 38 out of 66 patients who did not receive "educational care" were able to stay out of the hospital. In other words, three times as many of the "uneducated" had to return to hospital.

A study at St. Peter's Hospital in New Brunswick, New Jersey, showed that of a group of 50 patients with congestive heart failures, 23—almost half—had to return to hospital for a total of 600 bed days. After undergoing a program of education and counselling, only 6 had to be rehospitalized for a total of 140 bed days. Because of the progressive nature of this condition, hospitalization cannot be eliminated, but this amount of reduction in the most costly aspect of care is clearly worthwhile.

INFORMATION AND CONSULTATION OFFERED

Various other examples could be cited showing the impact of education on prevention, cure, or rehabilitation, but in the limited time available, I shall not cite others. The Society for Public Health Education has available to you here today other examples of research and demonstrations which suggest the potential that educational approaches have in reducing unnecessary human suffering and in reducing the waste of scarce health resources.

Additional documentation and technical consultation is available from the Society to this Committee or to any agency of government designated to pursue these matters.

ESTABLISHMENT OF FEDERAL OFFICE OF HEALTH EDUCATION

It is our contention that a health education benefit component be incorporated in the total health care benefit package included in any legislation to be passed by the Congress. In order to establish a focal point for leadership in developing these educational benefits, we recommend that the Department of Health Education and Welfare constitute an Office of Health Education to be charged with identifying and testing techniques and procedures of health education which hold most promise.

THE EDUCATIONAL COMPONENT IN NATIONAL HEALTH INSURANCE

Educational techniques selected for inclusion as a benefit in national health insurance must be those which can be made available universally and which can be easily and efficiently used by personnel possessing highly variable levels of educational skill and experience. Training costs in the use of new educational devices must be minimal in terms of time and money. Supervision and evaluation of the educational service also must conform to practicalities in the most modest health care setting. And, finally, the educational benefits component must have the potential for growth and variation appropriate to a given locale, clientele or situation.

There is time here only to give one example of a specific type of educational technique, that is, "a patient educational diagnosis and treatment plan." The idea is simple—it calls for a brief, structured interview of the patient at the time when the medical diagnosis is made. It is an inquiry into a patient's knowledge and concerns about the diagnosis and proposed treatment plan. Such information, incorporated as part of the patient's medical record, becomes the basis for a tailored explanation of what is required, and how well the patient understands the proposed regimen. Most importantly, *the educational diagnosis fixes responsibility for the educational effort* and guides the steps required for that patient to play his own role in regaining and preserving his health. Furthermore, such a device fits comfortably into the overall, well-established pattern of clinical evaluation, diagnosis and treatment. It would require rather modest investments in time and new training and the results are easily reviewed and comprehended.

EDUCATIONAL TECHNIQUES: ARE THEY READY?

Techniques such as patient educational diagnosis, like many other devices, have been limited in their application to a handful of scattered demonstrations. Much more needs to be done to test their efficiency, but further trials must be set with a particular operation and goal in mind. The methods must be treated within the costing and other constraints of a national health insurance program.

While it is clear that further development is necessary, it is equally clear that we need not start from scratch. We must begin *now* to cull the best that is available and consider a variety of pilot efforts within the context of existing health legislation, particularly Medicare. Specific proposals in this regard have been made to the Congress in the past, several from the Department of Health, Education, and Welfare. Now there is a new urgency. We simply cannot afford in hard dollars and cents terms to move into the area of blanket national health insurance coverage without the machinery—largely educational—to reduce wastage both of resources and human lives. Now is the time to be frankly pragmatic. If it works, let's get on with it. Let's take a fresh look at some of the exciting results of patient education programs such as those in New Jersey, California, Florida and elsewhere. Certainly, there is a sufficient basis in our present experience to have confidence in the belief that patient education, in an organizational arrangement which is supportive to its use, can reduce the short and long run costs of health care. Standing pat would mean that we are willing to live with a situation where, for example, thirty (30) percent of patients fail to follow their doctor's orders for reasons which must include failure to understand the importance of the prescribed regimen and for failure of the regimen to take into account the full story of the patient's situation.

SPECIFIC RECOMMENDATION

On behalf of the Society for Public Health Education, I would like respectfully to place before you our recommendation that a national health insurance program be enacted with the characteristics of universality described in the body of this statement; and that such a program fund an educational benefit with fixed responsibilities to:

1. Acquaint the public with the availability, benefits and limitations of the program;
2. Ensure continuous public knowledge of and participation in the planning, operation, and evaluation of the program;
3. Encourage the appropriate use of national insurance benefits in order to reduce length of stay in hospital, repeated unnecessary admissions for the same diagnosis, and failure to comply with medical advice;
4. Help patients achieve and maintain appropriate levels of self-sufficiency in personal health;
5. Assist all elements in the provider system to learn from patients as well as to teach them; and
6. Establish a patient feedback mechanism to help in spotting communications breakdowns and to contribute ideas to enhance effectiveness.

CONGRESSIONAL LEADERSHIP

For many years, the Congress of the United States has profoundly influenced the level of health in this country by taking leadership to set standards. Before the first World War, the Congress in establishing the Childrens Bureau created a mechanism to formulate health standards for women and children. During the mid-1930's the Congress established matching grants to states for Crippled Childrens programs which were required to meet standards for personnel, fiscal accountability and program. Today we make a plea that the Congress continue this tradition of setting standards for whatever program of national health care funding is adopted.

May I repeat the Society's sincere wish to be of service in advising in the technical design and testing of the educational component we believe is so crucial to the success and economic viability of a national health insurance program. Thank you.

OCTOBER 29, 1971.

APPENDIX

NATIONAL HEALTH PROGRAM GUIDELINES OF THE SOCIETY FOR PUBLIC HEALTH EDUCATION, INC.

We believe that health is a basic human right. In order to preserve and improve the health of the people of our nation, we believe that government, at its several levels, should create "a program that assures universal access to comprehensive and continuous health services of high quality, and in a manner that is efficient and economical".[1] Such a program should also have the following characteristics:

1. Appropriate education of patients within the categories of comprehensive service which include prevention, diagnosis, treatment and rehabilitation;
2. Consumers and providers participating equally in planning and in determining philosophy, administrative structure and procedures;
3. Consumers, their elected representatives and health professionals sharing in the continuous review of services rendered;
4. Universality of eligibility and coverage, with no restrictions as to age, sex, citizenship, residence, ethnic group, income or employment status or the nature of health condition, whether or not pre-existing;

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[1] Burns, Eveline, M., "A Critical Review of National Health Insurance Proposals", *HSMA Health Reports,* vol. 2, Feb. 1971, p. 111.

5. Equality of benefits available to all regardless of ability to pay;

6. Education of patients to develop appropriate utilization patterns, enhance participation in decision-making, motivate patients toward accepted health practices; and education of health professionals and other providers to develop the sensitivity, knowledge and skill to communicate effectively with consumers.

7. Education of both school age and adult population in prevention, health maintenance and appropriate use of services.

Mr. Rostenkowski. Thank you, Mr. Weidler.

Are there any questions?

Mr. Duncan?

Mr. Duncan. I have no questions.

Mr. Rostenkowski. Mr. Corman?

Mr. Corman. No, thank you.

Mr. Rostenkowski. Mrs. Keys?

Mrs. Keys. No, thank you.

Mr. Rostenkowski. Thank you very much for your testimony.

This will conclude the testimony for today.

The committee will adjourn until 9 o'clock tomorrow morning.

[Whereupon, at 12:04 p.m., the subcommittee adjourned, to reconvene at 9 a.m., Thursday, November 6, 1975.]

NATIONAL HEALTH INSURANCE

THURSDAY, NOVEMBER 6, 1975

U.S. House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in the committee hearing room, Longworth Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. I want to thank you, Mr. Meany, for joining with us this morning to give us your observations on national health insurance. It is always a pleasure to have you before our committee, and we sincerely appreciate your taking the time out to join us.

STATEMENT OF GEORGE MEANY, PRESIDENT, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS, ACCOMPANIED BY ANDREW BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AND BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY

Mr. Meany. Thank you very much, Mr. Chairman. Four years and 12 days ago, I testified on behalf of the AFL–CIO before the full Committee on Ways and Means in support of the national health security bill introduced by Representatives Corman and Vanik, and many others.

In those 4 years, health expenditures have increased 50 percent to more than $118 billion for fiscal 1975. Total Federal expenditures for personal health services have increased 86 percent to an estimated $28.6 billion for fiscal 1975. Federal expenditures for medicaid have nearly doubled in that time.

Today this Nation is spending more than ever before—8.3 percent of the total value of the goods and services it produces—for health care. And the sad fact is that despite all this money, despite the finest technology in the world, despite the greatest medical schools and the most highly trained doctors—despite all this, Mr. Chairman, the American people are not any healthier.

One thing that has not changed during the 4 years is the status of action on national health insurance. It is still at square one.

There have been two national elections in that time. Many of the successful candidates had pledged themselves to action on national health insurance.

There have been numerous public opinion polls which indicate strong and growing public support for a program like health security.

One of the principals in the national health insurance debate—organized medicine—has put forth a new proposal which, for that organization and only that organization, could be called more liberal.

The problems of access, cost, waste, duplication, poor quality—the undeniable health care crisis that exists in America—have become more critical.

Let me make it clear, however, that the past 4 years have not been entirely futile. The issue, the alternatives and the necessity for action have never been in sharper focus.

There have been, and continue today, efforts to confuse the question, particularly on the matter of cost. On this issue there has been honest confusion, honest disagreement and, regrettably, dishonest scare tactics.

So, our testimony here today will be frank: what we are for, what we oppose, and our views on the major controversies that this subcommittee must resolve.

In our opinion, a national health insurance program faithful to that name must include nine essentials:

A single standard of comprehensive benefits.
Universal coverage.
Access to health care as a matter of right.
Strong cost controls.
Built-in quality controls.
Incentives for reform of the health care delivery system.
Minimum administrative overhead cost.
Equitable financing.
Substantive consumer representation.

Only national health security—H.R. 21—includes each of these essential items. The other bills before you—which are analyzed in the attached appendix, which we will present to the committee—fail to come close to this standard.

Additionally, it should be pointed out that these items reinforce each other. We believe it is essential to have universal coverage if administrative overhead is to be kept to a minimum. Similarly, some of the strongest quality controls are also cost controls.

In my testimony, I intend to cover these points. However, there is one overriding question that dominates debate about national health insurance. And that is cost. How much will it cost?

Appended to my testimony is an excellent article by Dr. Rashi Fein of Harvard Medical School which places the cost issue in perspective. I urge every member of the subcommittee to read this article.

The bottle line cost of health security—the $100 billion figure that attracts the wrath of editorial writers and the attention of political speechwriters—is both its biggest drawback and the major source of the program's strength.

One hundred billion dollars is an incomprehensible figure. One is tempted to say that anything that costs $100 billion isn't worth it. But $100 billion is what this country is spending on health care today.

If health security were enacted tomorrow, its cost would not be $100 billion in addition to the $100 billion now being spent—as some of its opponents would like you to believe. Its cost would be the same $100 billion that is now being spent.

The health care system in America is a $100-billion industry right now. We are not talking about creating a new enterprise—a new health industry—when we speak of national health insurance.

Health security would take the same money that is being spent today by individuals, insurance companies, and governments to purchase health care for everyone.

So, while Federal expenditures for health care would increase, it would only increase by the same amount that other expenditures for health care are reduced.

The pie is the same $100 billion. The difference between all national health insurance proposals is how that pie is divided up.

That does not mean that there isn't a dime's worth of difference between the programs, since they would all cost about the same amount. There are vast differences.

First, the total cost of health security would be out in the open—the bottom line would be clearly visible to everyone. The true cost of other proposals would be hidden in many different budgets, millions of out-of-pocket expenditures, and hundreds of insurance company forms.

Second, only health security would use that money to purchase health care for everyone.

Finally, and most importantly, because health security has one budget, it is the only program that could effectively control its future cost.

There are those who say the Federal Government can only "afford" a $2 billion or $8 billion program. That is the height of political irresponsibility; $2 billion for a worthless catastrophic program or $8 billion for the Nixon-Ford program would be like pouring money down the drain.

Health security is a new and different financing mechanism—a new way, a better way of spending old dollars. The question "Can we afford it?" really answers itself. Certainly we can afford to spend what we are now spending. What we cannot afford is to continue to spend it in the same way.

This cost issue—which is really a nonissue—continues to confuse the debate about national health insurance. It is a recurring theme that is intertwined in a host of side issues. Hence, we will return to it often in our discussion of the nine essential elements of health security.

COMPREHENSIVE BENEFITS

Only health security provides comprehensive health benefits without deductibles or coinsurance, which are barriers to preventive care, early diagnosis and treatment. The reasons for comprehensive benefits are quite basic.

Health services follow the dollar. In the 1930's and early 1940's, when voluntary health insurance was mainly insuring hospitalization, the use of hospital services increased. When insurance was extended to surgery, the number of operations increased.

Similarly, the rapid expansion of major medical and catastrophic coverage has diverted health manpower and institutional resources into high-cost, specialized, technological care. This space-age medicine may be important where and when it is really needed, but it helps relatively few people. At the same time, very few private health insurance policies cover immunizations, laboratory and X-rays (except in confirmation of a diagnosis), well-baby care or physical examinations.

Unless a national health insurance plan finances the complete range of care, it distorts the best pattern of health services. Programs that rely on cost-sharing by the patient—deductibles and coinsurance—would continue emphasis on treatment for acute illness in expensive hospitals and high-cost treatment by specialists. Deductibles and coinsurance are barriers to health care, which discourage individuals from seeking proper preventive or early treatment.

Prepaid group practice plans, now often called HMO's, have proven the effectiveness—both financially and in health terms—of keeping people well rather than treating them only when they are ill.

Health security is criticized for providing comprehensive benefits without deductibles or coinsurance. Opponents make two basic arguments:

1. That deductibles and coinsurance control costs by making those who use a service pay part of its cost.

2. Without some type of copayment, the system would be swamped with malingerers seeking health services for every real or imagined illness.

The facts do not support these arguments. Actually, copayments increase, rather than decrease, the total cost of health care. They impose a financial barrier to necessary as well as unnecessary care; thus, the poor will defer seeing a physician until the illness is more acute and more expensive to treat. In addition, determination of cost-sharing factors increases administrative costs.

Deductibles and copayments limit the liability of insurers and the government. They constitute a convenient escape hatch for dealing with rising costs—by passing them through to the patient—without ever having to come to grips with the causes of these higher costs.

Allow me to point out two experiences with copayments—one in Canada under national health insurance and one in California under medicaid.

In Canada, deductibles are not permitted under the national health insurance program, but copayments are. In the Province of Saskatchewan medical services were initially free. Concerned with increased costs, the Province initiated a $1.50 per visit utilization fee for physician services in 1969.

This modest copayment did result in an 18 percent reduction in services for the poor, but an increase in physician services for the rest of the population. Thus, total utilization increased rather than decreased after the introduction of copayments. The only effect of copayments was to shift services from the poor to those able to pay.

The California copayment experiment imposed a modest $1 charge for the first two visits to a doctor and 50 cents for the first two drug prescriptions each month. The experiment compared a group of AFDC families with copayments to a matched group of AFDC families for whom no copayments were required. The results were independently evaluated by the UCLA School of Public Health, and I quote from that report:

In a word, it would appear from this study of the California Copayment Experiment with Medicaid beneficiaries that the state government's strategy was pennywise and pound foolish. Short-term savings for lower ambulatory care use were followed by definite increases in costly hospital use. As the experience of many health maintenance organizations has repeatedly demonstrated, comprehensive medical care, without cost-sharing deterrents is probably not only the best way to maintain a person's health. but is also most economical in the long run.

This is from the California report of the UCLA School of Public Health.

California discontinued copayments after 18 months.

UNIVERSAL COVERAGE

A national health insurance program should provide coverage for all residents of the United States regardless of age, income, or geographic location. Universal coverage under a single system of financing would make possible the elimination of all determinations of eligibility—a considerable savings in administrative cost.

Only health security provides for universal coverage. The coverage gaps in other bills result from dividing the population into separate groups such as the employed, the aged, the self-employed and the poor. Under these proposals, participation in the program would generally be voluntary; thus, many individuals would fail to enroll. They would play Russian roulette and gamble that they would not face expensive medical bills.

HEALTH CARE AS A MATTER OF RIGHT

In America, every citizen is entitled to a free public education as a matter of right. This right is not circumscribed by an income test to determine a family's tuition. Similarly, the right to health care should not be subject to an income test to determine how much a family must pay. That is why there is no income or means test in health security and no experience rating.

Our reasoning is both philosophical and practical.

We do not believe that it is morally right to treat the poor and the elderly as second-class citizens. We are repulsed by the idea of forcing human beings to go before some Government agency and publicly declare, "I am a pauper. I cannot help myself," before receiving help.

Further, we are disturbed at the attitude that would accept the establishment of yet another Government agency to keep track of the intimate details of every family's life and income.

This is different, we are told, because someone has to call out the chiselers—that faceless army of people just itching for the chance to rip off Uncle Sam. So the Government must keep extensive records on every American—the number of hours they work; how much did they earn; have they paid the deductible or coinsurance; how may times have they seen the doctor and for what?

To satisfy the rhetoric of reactionary demagogs about "welfare chiselers," this country would be spending much more money to hire people to police the program in order to deny medical care to a few people than it would cost to give them the care they need.

Mr. Chairman, under health security there would be no reason for "chiseling," because every American would receive the same comprehensive benefits, with no deductibles and no coinsurance. Thus, there would be no need for means or income tests.

The saving in administrative costs would be used to purchase health care instead of redtape.

If health care is to be a right, everyone should be in one risk pool and health services should be distributed on the basis of each individual's need.

There should be no experience rating of health insurance premiums or taxes based on how sick or well an individual or group may be.

Moreover, experience rating makes no sense since people are relatively healthy when young and relatively sickly when old. Should old people on limited incomes pay more for health care?

National health insurance should spread the risk of illness both over the life span of each individual and across the entire population. This is a basic principle of social insurance in contrast to private insurance, which places more of the financial burden of health insurance on the sick, the poor and the old. It is interesting to note that the private insurance carriers propose, under the guise of "national health insurance," a program which gives the Government the poor risks, while taking the profitable risks for themselves.

Experience rating is not only morally wrong, it is also expensive. Experience rating would add to the administrative overhead of any national health insurance plan.

COST CONTROL

One thing the United States should have learned from the medicare experience is that paying physicians on the basis of usual and customary fees and reimbursing hospitals on a cost-plus basis leads to inflation of physician fees and hospital charges. An essential goal of H.R. 21 is to contain the escalation of these health expenditures.

Most of the bills that have been introduced make the claim that deductibles and coinsurance would contain patient utilization and, therefore, costs. But it is the doctor, not the patient, who controls utilization.

After the first contact with the physician, which is initiated by the patient, the doctor establishes the patient's course of treatment. The doctor advises the patient when he or she should come back for a follow-up office visit—next week, in 10 days from now, or next month. The doctor orders the lab tests and X-rays. If the doctor deems it advisable, he or she hospitalizes the patient and decides when the patient can be discharged. The doctor writes the prescriptions, gives instructions to interns, residents, and nurses. Thus, the medical profession is unique in that physicians not only supply health service but also create the demand for services.

If the law of supply and demand meant anything in the medical field, then physician fees in Washington, D.C., should be the lowest in the country. After all, this area has the highest physician-to-population ratio in the country—one doctor for every 296 people. There are three medical schools, the National Institutes of Health and scores of research and clinical facilities.

But physician fees in Washington are among the highest. In rural areas where doctors are few, the fees are much lower. Similarly, the oversupply of surgeons has not lowered fees; it has resulted in more surgery.

The delivery of medical services is a monopoly of the medical profession. And it should be dealt with as a monopoly. That is, if medical costs are to be controlled, the medical monopoly must be confronted with a countervailing force of sufficient strength that it can modify the behavior of physicians. The financing of health care can provide this countervailing force, but only if all payments are channeled through a single public agency, as in health security.

Basically, there are three approaches to cost containment. One approach would be a national health service, similar to Great Britain. The AFL–CIO does not favor this approach, and it has virtually no support in this country.

The second approach would attempt, through regulation, to curtail the excesses of the present fee-for-service private insurance system. There are very real reasons for believing that regulation of the health industry would be both ineffective and expensive. Regulation would, in all likelihood, freeze the present ineffective and costly fee-for-service system and add another layer of regulatory costs on top of already burdensome overhead costs.

Regulation of the health industry would be ineffective and costly because the task of regulating about 250,000 medical entrepreneurs, many of whom are in solo practice, would be enormous. Some of them would be figuring ways to beat the system. The regulators would attempt to catch the bad guys with more regulations that would also enmesh the good guys in a complicated maze of redtape. Before long, the delivery system would be in a straitjacket.

Also the dividing line between what is extravagant care and what is quality care is extremely difficult, if not impossible, to draw. Physicians have a legitimate if exaggerated, fear of "cookbook" medicine, but regulation would likely move the system slowly in this direction.

The main problem with leaving the financing of health care in the hands of the insurance industry and relying on regulation to contain costs and maintain quality is that the economic incentives of the providers are in the wrong direction. A case in point is the ineffectiveness of medicare and medicaid regulations in controlling the cost and quality of health services.

However, there is a third alternative—the budgeting of health expenditures. This would leave the delivery of health services in the private sector. In other words, the present ownership of hospitals and the private practice of medicine would not be affected. But, in a budgeting system, the financing of health care would necessarily have to be in a single agency.

This is the approach of the health security bill that the AFL–CIO supports. The national budget for health expenditures would be a set amount in any given year. This national budget would be allocated to health regions and in turn to health service areas. Overdoctored health service areas would receive a somewhat lower budget, on a per capita basis, than underdoctored areas for physician services. This is an incentive for a better geographical distribution of physicians. Similar considerations would apply to facilities.

Because of built-in cost controls in budgeting system, it does not rely on detailed regulation to control costs. Essentially, providers would have far more freedom to experiment and innovate under a budgetary system than under a regulatory system. Their main restraints is living within the budget—one flexible enough to meet the contingencies of massive medical emergencies.

This would reverse the incentives of the fee-for-service system in the direction of more economical use of resources in delivering health care. It would also provide incentives for physicians to become involved in better organizational arrangements for the delivery of care.

Under a budgeting system, hospitals would be expected to live within a prenegotiated budget, but they would receive a check periodically with very few strings attached. Likewise, physicians who would elect capitation as their preferred method of reimbursement under health security would receive a check for the patients who elected to enroll with them. Almost all paperwork associated with a separate claim submission for every service would be eliminated.

To be effective, regulation must control the quantity, the price, and location of treatment. Thus, the implications of interference with the practice of medicine are very large indeed.

Regulation could preempt the physician's judgment in medical decisions. Yet, all of the principal bills, except health security, rely on regulation to control costs.

A study of medicaid by the Medical Services Administration[1] of HEW states, and I quote:

> The number and complexity of the regulations make them difficult to enforce. First, the demands that the regulations make are many and difficult. Complete compliance in the strict sense is probably impossible, and the department has never required it. Second, once some regulations are not enforced, it becomes unclear which regulations are really mandatory. This makes it difficult to insist on compliance in a particular case.

This is the end of the quotation from the study of the Medical Services Administration of HEW.

Shouldn't past experience instruct us? Regulation by edict is administratively cumbersome and medically inhibiting. We believe budgeting, which is essentially self-regulation, is the only system that can and will control costs.

QUALITY CONTROLS

Most of the national health insurance bills, except health security, make no provision for the quality of health care that would be rendered to patients. For this purpose, Professional Services Review Organizations, though important, are not enough.

Quality control should be an integral part of any national health insurance program enacted by Congress. The health security bill establishes the Commission on the Quality of Health Care at the Federal level. This commission would have the continuing responsibility of developing and enforcing national standards for participation by doctors, hospitals, and other institutional providers.

REFORM OF THE DELIVERY SYSTEM

Today the delivery system of health care is an uncoordinated, inefficient and expensive nonsystem. Transforming that into an efficient system that delivers quality health care to all will require some fundamental changes in how people get their medical care.

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[1] "Medicaid 1977–81—Major Program Issues."

First, the profit-motive ethics of the marketplace must be replaced by a primary commitment to improving the health of the American people.

Second, the country must develop organized systems of delivering health care. This should be accomplished as part of a total program, not as an isolated effort. The Health Maintenance Organization Act of 1973 is a positive step forward, but it cannot achieve its full potential until America provides the financing for comprehensive care.

Health security would provide integrated, systemwide reform of the health care delivery system. This does not mean that health security would scrap the existing system; rather it would build on the existing foundation. Through incentives and a Health Resources Development Fund, the system would be encouraged to reform itself.

ADMINISTRATIVE COSTS

Most of the bills before this committee would mandate or subsidize the extension of private health insurance.

In Canada, the national health insurance program in most provinces is administered by government. Several of the provinces initially attempted to utilize private insurers in the administration of their program. Canada found that private insurance was expensive in terms of the mechanical function of processing claims and, more importantly, incapable of influencing the delivery system to be responsive to the needs of the population. For these reasons, most provincial governments have phased out private insurers.

The cost of administration of the hospital insurance program in Canada—including both federal and provincial cost—is 1.5 percent of total hospitalization expense. For the United States, this compares with a Blue Cross administration expense of 8.9 percent of hospital claims in 1973. Thus, Blue Cross is seven times more expensive than Canadian Government administration.

The average Canadian cost for administration of hospitalization and medical service combined is 4 percent of expenditures for health services. This compares to an operating ratio of 13 percent for commercial group policies in the United States for the same year.

Australia had a program similar to the bills supported by the American Medical Association and the Health Insurance Association of America from 1953 to July 1, 1975. That is, pensioners were covered by a Government program, and the Federal Government subsidized the premium payments for the poor and near poor for coverage under private health insurance. Like the AMA and HIAA bills, there was a significant amount of copayments required by the patient.

The cost of administration of this subsidized private insurance program in Australia was 25 percent of claims. Because of this high overhead cost, as of July 1, 1975, the voluntary insurance funds were replaced by a single funding agency under the direct supervision of Australia's Department of Social Security.

Thus, in two countries—Canada and Australia—private health insurance as the basis for so-called national health insurance has been tried and has failed to provide health care at a reasonable cost for administration.

Cost savings can be achieved in a governmentally administered program by eliminating such functions as (1) determination of eligibility,

(2) processing claims with deductible and coinsurance provisions, (3) costs associated with experience rating, (4) income or means tests, (5) establishing a separate money collecting system such as for the collection of premiums and (6) marketing costs.

Where a national health insurance program covers everybody and the plan is administered by a single agency, no determination of eligibility is necessary. Only the health security bill establishes health care as a right for all citizens.

The complexities of administration resulting from variable deductibles and coinsurance as individuals move up and down the income ladder are enormous. For example, in Los Angeles the turnover of medicaid eligibles is 70 percent a year. Yet all the bills, except health security, have such income tests. All of the complexities of income determination could cause a minimum overhead waste of several billion dollars which would be used to hire an enormous number of clerks, claims processors, eligibility determinators, and adjustors.

The tax collecting machinery for payroll taxes, which health security would use, is already in place. For the other proposals, the administrative cost of collecting premiums would be an added expense. In addition, high cost individual policies only pay out 53 percent of premiums in benefit claims.

Another major waste in the other proposal is the cost of marketing a multiplicity of different benefit packages. While all of these bills would require a minimum benefit package, the possible variations over and above this minimum package would be endless. It should be emphasized that the minimum package would also be the maximum package for the poor, but the employed and the more affluent would be able to purchase more comprehensive coverage, either through collective bargaining or by direct purchase.

Since health security provides comprehensive benefits for all Americans, marketing costs for different policies would disappear.

Because health security eliminates the factors that cause high administrative costs, health security could be administered at a cost comparable to Canada's or for about 4 percent of the cost of medical services provided by the program. The other bills, on the other hand, are similar to the program that Australia had to abandon because of the cost of administration.

Low overhead costs for administration should be a major objective of any national health insurance program adopted by Congress.

FINANCING

The American people pay for their health care in four ways: (1) by out-of-pocket payments at the time health services are rendered, (2) by health insurance premiums, (3) by payroll taxes as required under medicare and (4) by income taxes.

Out-of-pocket payments are the most regressive way of financing health care because the poor and the unhealthy have a greater need for health services than the more affluent and less sickly. Out-of-pocket expenditures are, therefore, higher for the poor and unhealthy than for the rich and healthy. Premium payments for health insurance are also highly regressive since, in effect, they are a flat head tax.

Social security taxes are more directly related to income. Income taxes are progressive.

The rival bills to Health Security rely primarily on out-of-pocket payments by patients and on a head tax in the form of health insurance premiums.

Health Security would be financed by a payroll tax matched by general revenues. Out-of-pocket expenditures by patients would be eliminated for physician and hospital services, and the flat premium consumers pay under private health insurance would be abolished.

CONSUMER PARTICIPATION

Of the many bills before you, only H.R. 21 and H.R. 1 provide any role for consumers in the development and administration of the Nation's health program.

The interest of the American public in national health insurance stems from the belief that such a program must be able to control costs and make health services accessible to the entire population. For too long all decisions about medical care have been made by doctors, hospital administrators and insurance company executives. It is time that consumers had a direct role in the administration of health care.

Mr. Chairman, 4 years ago, when I concluded my testimony before the full committee, I said that I hoped that we wouldn't have to come back to the next Congress to testify again on national health insurance. I repeat that hope at this time.

The American people have waited long enough for congressional action on this issue. We believe it is vital that this Congress at long last, enact a national health security system for America.

Health security makes economic, medical, and humanitarian sense. It is a program whose time has come, and we urge speedy action on it.

[Appendixes to the prepared statement follows:]

APPENDIXES

Five appendixes follow including a summary of the Corman bill (H.R. 21) and a summary and analysis of the other bills that appear to have some support in Congress at the present time. These bills include the National Health Care Services Reorganization and Financing Act (H.R. 1) supported by the American Hospital Association, the National Health Care Act of 1975 (H.R. 5990) supported by the Health Insurance Association of America, the Comprehensive Health Care Insurance Act of 1975 (H.R. 6222) supported by the American Medical Association and the Catastrophic Health Insurance and Medical Reform Act (H.R. 10028).

All of these bills except Health Security have certain features in common. All would establish different programs and/or different financing mechanisms for different classes of people such as the poor, the aged, the employed or "uninsurables." All rely heavily on an income test as a way of reducing premiums and/or copayments by poor persons in order to make health insurance available to those who otherwise could not afford to pay. This denies the concept that health care is a right of all citizens.

All of the bills, except H.R. 21, continue the vicious and antisocial practice of experience rating which requires the aged, the poor and mothers of childbearing age to pay higher premiums for the same protection as is provided to other citizens. None of the alternative proposals to Health Security provide universal coverage. None provide a single standard of comprehensive benefits for everybody. None have effective cost or quality controls. None have effective provisions to reform the delivery system; in fact, all would provide a financial underpinning for the fee-for-service system making change more difficult. All of the alternative bills are regressively financed. All would be very expensive to administer.

The following appendixes are attached:

Appendix A—Summary of the Health Security Act—H.R. 21.

Appendix B—Summary and Analysis of the National Health Care Services Reorganization and Financing Act—H.R. 1.

Appendix C—Summary and Analysis of the National Health Care Act of 1975—H.R. 5990.

Appendix D—Summary and Analysis of the Comprehensive Health Care Insurance Act of 1975—H.R. 6222.

Appendix E—Summary and Analysis of the Catastrophic Health Insurance and Medical Reform Act—H.R. 10028.

APPENDIX A—SUMMARY OF HEALTH SECURITY, H.R. 21

The National Health Security, H.R. 21, program was introduced in the 94th Congress by Congressman Corman (D-Calif.) with 7 cosponsors from the Ways and Means Committee and with a total of 102 cosponsors in the House of Representatives. The bill would establish a comprehensive national health insurance program for all residents of the United States financed by a combination of payroll taxes and federal general revenues. H.R. 21 is supported by labor and 40 other organizations including some providers organizations and church groups, consumer groups, membership organizations and welfare groups. The bill would consolidate the financing of health services through a Health Security Board under the direction of the Secretary of Health, Education and Welfare in order to establish a national health expenditures budget to control medical care costs.

ELIGIBILITY

Every citizen and permanent resident of the United States would be eligible for Health Security benefits. Unlike other proposals there would not be one plan for working people, another for those who are unemployed, one for the destitute and another for senior citizens. The Health Security approach guarantees the same quality care for everyone as a matter of right.

BENEFITS

The program would have no exclusions for pre-existing conditions; no limits on preventive medical services; no coinsurance; no deductibles; no waiting periods.

PHYSICIANS SERVICES

Professional services by physicians, furnished in their offices or elsewhere, would be covered in full. This includes general medical and specialized services.

All major surgery and other specialized care would be covered if performed by qualified specialists.

Psychiatric services would be provided to outpatients if given for active treatment of emotional or mental disorders and if provided by comprehensive mental health organizations. Otherwise, there would be a limit of 20 consultations by a psychiatrist during a benefit period.

DENTAL SERVICES

At the start, Health Security dental benefits would be limited primarily to children up to age 15, with the coverage including preventive, diagnostic and therapeutic services.

The age of eligibility for full dental care would be extended to persons up to age 25 during the first five years of the program's operation and the younger people would remain eligible throughout their lives. The increase of coverage could be accelerated if the Health Security Board believes it is feasible.

INSTITUTIONAL SERVICES

Health Security would provide full payment for hospital services; skilled nursing home care up to 120 days per benefit period or for an unlimited time if the home is owned or managed by a hospital or provided by a health maintenance organization.

The program would also include pathology and radiology services and all other necessary services whether furnished by a hospital or other institution or by others under arrangements with such institutions.

DRUGS

Health Security would cover drugs for hospital inpatients and outpatients and for persons enrolled in comprehensive group practice plans and professional foundations as long as the drugs were from an approved list.

For others, drugs would be covered if they were necessary for specified chronic diseases and conditions requiring long or costly drug therapy.

The purpose of the approved drug list would be to assure the safety, effectiveness and reasonable cost of the prescribed drugs.

DEVICES, APPLIANCES, AND EQUIPMENT

Health Security would provide coverage of therapeutic devices, appliances—including eyeglasses, hearing aids and prosthetic devices—and equipment. An approved list of covered items would be prepared and reviewed regularly.

OTHER PROFESSIONAL AND SUPPORTING SERVICES

Health Security would cover professional services of optometrists and podiatrists; diagnostic services of independent pathology laboratories; diagnostic and therapeutic services of independent radiologists; mental health day care services furnished by a health maintenance organization or comprehensive community health center, or 60 days of care furnished, during or following a benefit period, by a hospital or a center affiliated with a hospital; ambulance services; other professional services as psychological counseling, physiotherapy, nutrition, social work and home care or health education when furnished as part of institutional services or through health maintenance organizations; and diagnostic and therapeutic services of free-standing alcohol, drug abuse, family planning and rehabilitation centers.

SOCIAL CARE SERVICES

Grants would be provided to local nonprofit organizations to develop social care services to aid chronically ill, aged and other homebound patients. Under this section, while some measure of local financing is developed, Health Security would cover homemaker services, transportation and other social care services as a demonstration of the usefulness of such benefits in reducing unnecessary long-term institutional care.

ADMINISTRATION

Health Security would be administered at four levels—national, regional, area and local—with some important functions carried out by states.

NATIONAL

Overall Health Security policy and regulation would be established and carried out by a five-member, full-time Health Security Board appointed by the President and under the supervision and direction of the Secretary of Health, Education and Welfare.

The members normally would be appointed for five-year terms, with one member serving as chairman and with no more than three members from the same political party. The program would be administered through an Executive Director appointed by the Board.

To assist the Board in carrying out its functions and to advise and recommend various changes or actions, a 21-member National Health Security Advisory Council would be established. A majority of the membership of the Council would be consumers of health services. The council would be authorized to appoint professional and technical committees to carry out its functions.

The Secretary, Board and Executive Director would all work to assure effective coordination of Health Security with existing HEW programs—and with programs in the regions and states—for the development of health facilities and manpower resources, medical research and public and community health services.

The Health Security Board would control expenditures from the Health Security Trust Fund, establish national benefit patterns, set standards of participation and develop policy guidelines. The Board would also have the responsibility to assure effective consumer participation and public accountability at all levels.

The Board would also have responsibility for studying systems of paying for services and for planning new developments and improvements for health services.

A commission on quality of health care would be established and charged with assuring the developing standards of care of high quality.

REGIONAL AND HEALTH SERVICE AREAS

At the second and third level of administration for the Health Security Program, 10 regional Health Security offices would be established within the regions of the Department of HEW and more than 100 health service areas would be established paralleling the natural medical delivery patterns in the United States. The health service areas normally would consist of a state or part of a state. Interstate areas would be established where the board found that patterns of health service organization and patient flow made an interstate area more practical for administration.

LOCAL

As the fourth level of administration, the Health Security Board would establish in each health service area a local Health Security office and any necessary branch offices. These offices would assist health service consumers and providers and serve an ombudsman function by investigating complaints concerning administration of the program. They would also have informational and other administrative functions.

STATES

States would participate in Health Security in a number of ways. They would participate in planning, training, coordination for quality controls and manpower increases, health, education, utilization review and the inspection of providers. The Health Security Board would establish appropriate payment arrangements with the states for services. To improve the supply and distribution of health personnel and facilities and the organization of health services, the board would work with state comprehensive health planning agencies.

EXISTING PROGRAMS

A number of major federal health programs would be superseded in whole or in part by Health Security.

MEDICARE

Everyone 65 and over would be entitled to Health Security coverage. Benefits would be broader than those offered under Medicare. Medicare would be terminated.

MEDICAID

The benefits of state Medicaid programs would be available under Health Security. Such benefits would be deleted from Medicaid, leaving it as a supplementary program to Health Security. States would claim partial reimbursement for services provided which exceed those available under Health Security. This would include long-term nursing home care, drugs and adult dental care.

WORKMEN'S COMPENSATION

Because separation of the health service benefits of Workmen's Compensation programs from cash payments would unduly complicate the eligibility determination process, Workmen's Compensation would be unaffected by Health Security.

OTHER PROGRAMS

Material and Child Health Programs, Crippled Children Programs, Office of Economic Opportunity Health Programs and Medical Vocational Rehabilitation provide a range of various services to specific groups. In addition to a personal health service component, each program covers other types of health and community service which would be continued.

FUTURE PLANS

In order to broaden the scope and benefits of Health Security to remove its initial limitations, the program would undertake various studies, including long-term care, coordination of Veterans Administration health care programs with Health Security, and the provision of Health Security benefits to U.S. citizens in other countries.

FINANCING

Health Security would be financed through a trust fund similar to the Social Security Trust Fund.

Fifty percent of the money would come from: a 3.5 percent tax on employer payroll; a 1 percent tax on the first $20,000 a year in wages and non-earned income and a 2.5 percent tax on the first $20,000 a year of self-employment income. The remaining 50 percent would come from federal general revenues. If an employer's existing obligations for the purchase of health benefits for his employees are greater than 3.5 percent of payroll, the excess would be applied toward the 1 percent which would otherwise be withheld from an employee's wages. The first $5000 income for persons over 60 would be exempt from Health Security tax. The total of these taxes and the government matching funds would be the total available to pay for personal health services in each fiscal year. After setting aside contingency reserves and money for the development among the ten regions of the country. This would be done with regard for recent and current use and expenditure patterns for services covered by the program.

Initially, the Health Security Board would look to the latest expenditure figures available before the program starts, making appropriate adjustments among the regions for figures higher or lower than the average. After that, the allocation among regions would be guided by actual expenditures and estimates of what was needed to meet the program's obligations and objectives. The Board would budget funds for each of the new HEW regions in each category of covered service from the total sum allocated to the region. There would be authority for each rgion to determine its own needs and priorities in support of services.

COST AND QUALITY CONTROLS

The central cost control feature of the Health Security program is that the health care system would be anchored to a budget established in advance. The program's main quality control feature would be the establishment of national standards for participation both for individual and institutional providers. To develop and endorse such standards, a Commission on the Quality of Health Care would be established. It would be a quasi-independent board reporting to the Health Security Board, but with authority to appeal to the Secretary of Health, Education and Welfare if it believes the Board has failed to implement or enforce effective quality standards.

BUDGETING

The Health Security Program would establish an advance budgeting procedure for the costs of personal health services. Each year an advance determination would be made of the total amount to be spent in the various regions on physicians' services, institutional services and other categories of service provided in local communities. The cost of each kind of service and the overall cost of the program would be allowed to increase only on a controlled and predictable basis.

The program would use the budgetary process not merely to control costs, but also to strengthen local, state and regional planning, stimulate more efficient institutional administration; and gradually reverse the current undesirable emphasis on inpatient hospital and other institutional services. This would be done by stressing preventive and early curative services and by making alternative levels and forms of care available outside of institutions. In approving budgets for institutions, the program would consider recommendations and decisions of state and other health planning authorities, administrative efficiency of the institution, scope of care provided and the need to achieve an equitable distribution of resources throughout the region and country. Wasteful duplication of services and facilities would be gradually eliminated by withdrawal of funding. Institutional budgets would be increased to allow for the provision of services needed for a balanced development of regional resources.

NATIONAL STANDARDS

The national standards for provider participation would be designed to upgrade the quality of care, encourage appropriate use of health manpower and promote orderly planning of facilities. Physicians, dentists, osteopaths, optometrists and podiatrists licensed to practice in a state when the program begins would be eligible to take part in the program as long as they met continuing education requirements. The Health Security Board would be authorized to establish national standards for professional personnel licensed after the program begins and to set requirements for their continuing education. Hospitals, skilled nursing homes, home health agencies, specified freestanding centers, medical or dental foundations and health maintenance organizations would be eligible to participate if they met national standards established by the Board.

Institutions would be required to establish working relationships with other providers of care so that a patient would have continued and appropriate treatment. Institutions which refused to comply with local and regional plans required by the Board would not be eligible to participate in the program.

PAYMENTS TO PROVIDERS

Hospitals, skilled nursing homes and other types of institutional providers would operate on an approved budget basis rather than being able to charge whatever they decided. Using the previous year's fiscal experience and taking into account standards of participation, range of desirable services and quality controls required by Health Security, the institutions would develop proposed budgets for the next fiscal year. They would be assisted by the regional and local offices of Health Security in preparation of their budget requests. The budgets would be reviewed and given final approval at the regional office level. Money allocated for payment of individuals, such as physicians, dentists, podiatrists etc., would be distributed to local areas within the region. This would be done on a per capita basis with adjustments for differences in the cost of goods and services. The budgeted per capita amount for each type of covered service would be divided between the categories of providers according to the number of individuals who elected to receive care from those providers. Under Health Security, providers would have to agree not to charge individuals for all or part of any service provided. Payment would be made directly by the program in full to the provider or to the agency representing him. No billing of the patient or indemnity payment to him. Health maintenance organizations and professional foundations accepting responsibility for providing or securing all covered services for a defined population would receive the total amount budgeted and negotated as payment. They would share also in the savings they helped to achieve by preventing unnecessary hospitalization of their enrollees.

CONSUMER PARTICIPATION

Consumer organizations would be encouraged to give health care a high priority in their overall activities and to sponsor and develop comprehensive community-wide health care organizations. Along with health maintenance organizations to be developed by hospitals, physician groups and combinations of professionals, the programs developed by consumer-sponsored organizations would be supported and recognized by Health Security. The Health Security Board would assure effective participation by consumers at all levels of policy formulation and program development. There would be a majority of consumer representatives on the National Advisory Council assisting the Board in its continuing administration of the program, and on regional and local advisory councils. The make-up of the councils would have to reflect the composition of the state or community served. There would be public control of the basic policies governing the program and full public accountability for its finances and operations.

MANPOWER SUPPORT

Health Security would actively encourage more efficient organization of existing health manpower, provide funds for special training of physicians. dentists and other health personnel and apply financial incentives to stimulate the movement of health manpower to medically deprived areas.

Health Security would recognize costs incurred by HMOs in supporting the training and appropriate utilization of allied health professionals. It would pay the full cost of employing support personnel, such as nurse practitioners, public health nurses, nutritionists and community health workers, thus extending the abiilty of physicians to provide care and giving the consumer access to a wider range of services. Training funds could be used for the retraining of health workers to enhance or refresh skills or for new positions of greater responsibility. Money would be available through the Resources Development Fund to stimulate the expansion of training programs for new categories of health professionals, especially those required as members of primary health care teams—such as pediatric nurse practitioners, physicians' assistants and dental hygienists. Emphasis would be placed upon demonstration programs for the training and placement of allied health workers, and support would be available to institutions for the special costs of educating and training minority group and economically deprived students. In addition, special incentives would be used to increase the attractiveness of practice in rural or deprived areas for health workers and their families. There would be financial disincentives for the disproportionate clustering of physicians and dentists in a few metropolitan or suburban areas and corresponding incentives for their location in other areas.

RESOURCES DEVELOPMENT FUND

A substantial Resources Development Fund—administered by the Health Security Board—would help to increase the resources of services and to bring new organized programs of health service into being and to expand existing ones. The Resources Development Fund would be formed, first, by appropriations from federal general revenue for the period between enactment and when benefits began, so that system improvements could get underway promptly; and, subsequently, by taking a percentage of the annual income of the trust fund (2 percent the first year increasing in regular intervals to a maximum of 5 percent a year). A priority would be given in grants and loans to stimulate the development and growth of health maintenance organizations and social care services for handicapped and aged homebound patients. Essentially, the fund would recognize the responsibility of Health Security to assure the availability of covered health services, and not merely to pay for them. And, it would have concern for the development of services to meet the changing needs of people in the most effective and efficient manner.

APPENDIX B—SUMMARY OF THE NATIONAL HEALTH CARE SERVICES REORGANIZATION AND FINANCING ACT, H.R. 1

H.R. 1, introduced by Representative Al Ullman (D.-Ore.), is supported by the American Hospital Association. It would establish a program of national health insurance for most but not all residents of the nation. The bill envisions the establishment of a nationwide network of organized delivery systems which are called Health Care Corporations (HCCs). H.R. 1 would also consolidate federal health programs presently administered by the Department of Health, Education and Welfare into a new Department of Health headed by a Secretary of Health at the cabinet level.

FEDERAL FUNCTIONS

The newly created Department of Health would be responsible for federal supervisory and regulatory aspects of the health care program, setting basic standards for care and establishing the scope of health insurance benefits. It would have authority to review program activities at the state level. The Department of Health would have the guidance of a National Health Service Advisory Council which would include not less than one-half representatives of consumers.

STATE FUNCTIONS

Newly formed, independent State Health Commissions (SHCs appointed by state governors of which representatives of health care professions cannot constitute a majority would implement the federal legislation and federal regulations. They would develop state plans subject to approval by the Secretary of Health. SHCs would approve health service areas and health care corporations; control the rates charged by health insurance carriers and all providers through prospective determination; certify the need for services and facilities; carry out effective implementation of the state plan; and provide a system of judicial review.

State advisory councils, appointed by governors, representing providers and not less than an equal number of consumers, would advise SHCs on the implementation of state health plans.

HEALTH CARE CORPORATIONS (HCC'S)

These corporations would be community based not-for-profit, private or governmental organizations that would be charged with the responsibility of synthesizing local health resources for the delivery of comprehensive health services to defined population groups. They would serve geographical areas and provide comprehensive health services through their facilities and/or through affiliations with other providers, nonprofit and for-profit.

Every HCC would have to make available, within the state plan, comprehensive health services to everyone in its service area, including health maintenance service and services for catastrophic illness. Such services would be provided through the use of expanded outpatient facilities. After the first five years of operation, an HCC would be required to offer, as an option to its registrants, service on a capitation basis of payment.

HCCs could span political boundaries where necessary. They would be expected to extend services into underserved areas, rural and urban. While rural areas would be served by a single HCC, populous urban areas could have the services of a number of HCCs.

BENEFITS

Initially, the program would provide the Medicare level of benefits plus additional catastrophic coverage, which would take effect after health expenditures by or on behalf of an individual or family, reached a specified limit graduated according to income. Medicare deductibles and copayments would not be applicable to low-income groups. At the end of a 5-year phase-in period, the following comprehensive health care benefits would be required of both the Federal program for the aged and poor and employer-employee plans:

I. PERIODIC HEALTH EVALUATIONS

a. Screening tests and exams.

b. All immunizations.

c. Well-baby care to age 5, with number of covered visits decreasing with age of child.

d. Dental services for children through age 7; for those initially covered, benefits extend through age 12: (1) One free routine exam per year; and (2) Extractions, fillings, etc.—20 percent copayment.

e. Vision services for children through age 12: (1) One free routine exam per year; and (2) Prescription eyeglasses—20 percent copayment.

II. PHYSICIANS' SERVICES AND ANCILLARY CARE

a. Services on outpatient basis in any appropriate setting (including the home) by physician or allied personnel under his supervision—10 visits per year with $2 copayment per visit.

b. Outpatient diagnostic procedures—20 percent coinsurance.

c. Hospital or outpatient center services.

d. Supplies, materials, use of facilities and equipment, including drugs used or administered in connection with outpatient services.

e. Ambulance services—20 percent coinsurance.

III. OTHER OUTPATIENT SERVICES

a. Outpatient institutional care program for mental illness, alcoholism, drug abuse—$2 copay per day.

b. Day care or other part-time services for mental illness, alcoholism, drug abuse—three visits or sessions in lieu of each day of inpatient hospital care allowable for such condition.

c. Drugs, prosthetic devices and equipment—$1 copay per prescription, 20 percent coinsurance for devices and equipment.

d. Home health services—200 visits with $2 copay per visit.

IV. INPATIENT SERVICES

a. Hospital care—90 days per illness. Copay $5 per day.

b. Extended care services—30 days per benefit period with $2.50 per day copay.

c. Nursing home care—90 days per benefit period with $2.50 per day copay.

d. Physicians' services to inpatients—$2 copay per visit of attending physician only.

FINANCING

Employers would be required to purchase for their employees and their employees' families the comprehensive level of benefits, as specified above and pay at least 75 percent of the premium costs. The self-employed and individuals are encouraged to purchase their own insurance by allowing them to deduct the total cost of their premium from their income tax. Registrants of HCCs would be entitled to 10 percent federal subsidy on their health insurance premiums. This subsidy, together with support for the planning, development and operation of HCCs, is for the purpose of providing incentives for the reorganization of the health care delivery system. This subsidy would be paid from general revenues.

Health services for the aged would continue to be financed through a combination of the Medicare Social Security tax and general revenues. Those parts of Medicare which pay for institutional services (Part A) and for physicians services (Part B) would be merged, eliminating premium payments by individuals for Part B. Health insurance for the poor and the premium subsidy for the medically indigent would be paid by the federal government. Provision is made for a study to test the feasibility of a trust fund to provide supplemental capital financing for HCCs and other related organizations for the development of necessary health resources for the delivery system.

ANALYSIS

H.R. 1 would establish a single minimum standard of benefits for three groupings of the population, namely: (1) the employed, (2) the poor, near poor and the aged and (3) the self-employed and individuals. There are some features of the bill that are deserving of support such as: a commitment to develop organized systems of health care delivery which the bill calls Health Care Corporations, and a broad scope of benefits.

However, the bill has serious deficiencies and does not conform with the standards which the AFL–CIO has adopted for evaluation of other national health insurance proposals. These standards, which only National Health Security fully meets, are: Quality health care as a matter of right; universal coverage; comprehensive, single standard of benefits; financing through the proven social insurance method; strong cost and quality controls; reform of the health care delivery system; and strong consumer representation.

The same criteria are used to evaluate H.R. 1.

Health care as a right

The bill states in its declaration of purpose that "health care is an inherent right of each individual and of all people of the United States." Yet, a means test would be imposed upon the poor and near poor to determine their eligibility for reduced health insurance premiums, deductibles, coinsurance and copayments under the program. The means test would be extended to the aged who are now covered by social insurance (Medicare) to determine their eligibility for catastrophic insurance benefits. An income test would also be imposed on the entire population for the catastrophic benefit. Every American family, except the poor and near poor, would be required to pay out-of-pocket 10 percent of his adjusted gross income before becoming eligible for full payment of all medical bills by the catastrophic program.

Thus, the bill abandons the principles of social insurance and actually extends the welfare concept to almost the entire population.

Universal coverage

The Ullman bill would cover most Americans. However, federal employees would be excluded. Also excluded would be the unemployed not receiving cash benefits under unemployment compensation and the self-employed and other individuals who could not afford the high premium rates for individual health insurance policies.

Unlike Health Security, H.R. 1 does not provide universal coverage.

Comprehensive benefits

Initially, the program would provide the Medicare level of benefits plus catastrophic coverage to most of the population. At the end of a 5-year phase-in period, the benefits would be very comprehensive except that the benefits would be subject to substantial coinsurance and copayment provisions. There would also be many limitations. There would be for example:

Coinsurance of 20 percent on outpatient diagnostic procedures, medically needed devices and equipment including eyeglasses, routine dental care for children and ambulance services.

Copay provisions of $2.00 on physician visits (office, home and hospital) visiting nurse care, outpatient and institutional care. $5.00 per day for hospital care and $2.50 per day for skilled nursing home care and $1.00 for a drug prescription.

Limitations including well baby care to only age 5 with the number of visits decreasing with the age of the child (8 visits annually under age 1, 4 visits from age 1 to 2, and 2 visits from age 2 to 5); dental care for children up to age 8; physician visits limited to 10 per year for adults; inpatient mental health benefits limited to 135 sessions on an outpatient basis (3 sessions to substitute for one day of inpatient care); hospital care limited to 90 days and nursing home care to 120 days. After the income test has been met, catastrophic insurance would take over full payment for covered benefits.

The bill would, therefore, require substantial out-of-pocket expenditures by the patient.

In contrast, National Health Security would provide comprehensive benefits without coinsurance and copay provisions. There would be very few limitations on benefits under H.R. 21 and S. 3 and none where the benefits were provided in an organized setting such as a group practice prepayment plan. Catastrophic benefits would be provided without an income test.

Financing

The bill would require employers to provide the mandated package of insurance benefits (or the actuarial equivalent of such benefits) for their employees and pay at least 75 percent of the total premium cost. For those not covered by employer plans, the federal government would purchase insurance for the poor and subsidize the premiums for the "medically indigent" from general revenues.

The Medicare payroll tax on employers and employees would continue to finance Medicare benefits for four years, but starting with the fifth year, Comprehensive Health Care Benefits would be substituted for the Medicare benefits, but the Medicare payroll tax would continue.

The self-employed and individuals would be responsible for purchasing their own insurance, but the premium cost of such coverage would be allowed as an income tax deduction.

Thus, the program would be primarily financed by private insurance premiums supplemented by payroll taxes under Social Security, contribution from general revenues and deductions from taxes.

This pluralistic system of financing is exactly what the providers have, what they want and what they will fight to continue. It allows them to set their own charges and fees. If any such purchaser of health services feels that the cost is too high, such purchaser does not control enough of the funds to bargain effectively with the providers.

Because the great bulk of contributions for health insurance would be channelled through the insurance industry, all employer-employee coverage and individual insurance policies would be experience-rated. This means the old, the sick and mothers of child bearing age would pay the most and the young and healthy would pay the least. Thus, employers would be discouraged from hiring mothers and older and disabled workers.

Experience rating adds to administrative expense and makes no sense in a national health insurance program because at birth every person has an equal chance of being relatively healthy or relatively sickly. Every person at birth can anticipate being relatively healthy while young and being relatively sickly when he or she grows old. The entire population is the ideal risk pool. Nothing can be accomplished by splitting the population into "good" risks and "poor" risks except to add to administrative cost.

H.R. 1, unlike Health Security, is not financed in accordance with sound social insurance principles.

Cost and quality controls

The State Health Commissions under H.R. 1 would be given the responsibility for approving on a prospective basis all charges for services by providers including Health Care Corporations. They would also have the responsibility for regulating the premium rates of insurers. Thus, the bill would rely on the states to control costs, but the states have demonstrated very little competence in controlling health care costs or in restraining the premium increases of insurers. Moreover, the states would have very little power to restrain increases in hospital charges or doctor fees because they would not control any funds. The insurance industry would have all the money to pay providers.

The Secretary of Health would prescribe standards of quality and safety for Health Care Corporations, but not for other providers. The states would rely on peer review systems established by the providers themselves to provide surveillance over the cost and quality of care. While we favor appropriate use of peer review, it is not sufficient to restrain cost increases or assure quality of care.

In comparison to National Health Security, the cost and quality controls under H.R. 1 must be considered weak.

Reform of the delivery system

Superficially, H.R. 1 appears to place a major emphasis on changing the delivery system. The bill envisions blanketing the country with Health Care Corporations (HCCs) which would be responsible for providing the full range of health services including preventive care, outpatient and inpatient services and rehabilitation. These HCCs would have the responsibility for providing these services to all citizens residing in a given area.

It is clear the intent is that the HCCs would be organized and controlled by providers. Significantly, the bill does not require one-half of the governing boards of the HCCs to be consumers—only an "equitable" number of consumers.

Incentives for the development of HCCs include Federal grants for HCC development and an incentive for consumers to enroll in such health plans by providing a 10 percent Federal subsidy of the premium cost of belonging to an HCC.

However, for the first five years, there is little incentive for the corporations to move from fee-for-service to capitation as a way in which to reimburse their medical staff. After the expiration of the five year period, the Secretary of Health would be authorized to make grants only for HCCs which "operate primarily on the basis of predetermined capitation charges". This means HCCs could enroll subscribers on capitation basis, but could continue to reimburse their physicians on a fee-for-service basis and still qualify for Federal grants. Yet, the key to cost control and to the efficient delivery of health care is encouraging the spread of capitation as a method of reimbursing doctors.

The bill provides no incentives to doctors to join HCCs. There are only incentives for consumers. Yet, it is the physicians and not the consumers who have fought the development of organized systems for delivering health care. The labor movement and other consumer groups have established prepaid group practice plans only over the bitter opposition of organized medicine. How then, are HCCs to be organized if doctors do not wish to participate? Significantly, except for hospitals affiliated with medical schools, only one or two voluntary hospitals have organized health maintenance organizations. Basically, the reason is that the medical staffs of the hospitals just will not cooperate.

H.R. 1, therefore only promises reform of the health delivery system but the provisions of the bill are inadequate to achieve the goal.

Consumer representation

H.R. 1 provides for advisory councils at the Federal and state levels to the newly created U.S. Department of Health and to the state health commissions. These advisory councils are to be composed of an equal number of providers and consumers.

On the key Health Care Corporations boards of directors the bill requires only an "equitable" number of consumers. HCC's would be key because they would have the responsibility of actually delivering health care. The national Department of Health and the state health commissions would be regulatory agencies with little authority for actually administering the program. The insurance industry would control payments to providers and thereby have more "clout" than the regulatory bodies.

Thus, the advisory function to essentially weak agencies does not really give consumers an effective role in the delivery of health care, and the "equitable" representation on the boards of directors of HCCs is, at best, vague.

In contrast, the Health Security bill provides for a majority of consumer representatives on all advisory councils: Federal, state and local. Moreover, these advisory councils would have input into agencies having direct line authority over the administration of the program.

With regard to consumer representation, H.R. 1 is a substantial improvement over the bills supported by the American Medical Association or the Health Insurance Association of America, but falls far short of the kind of effective consumer input that is provided under National Health Security.

Appendix C.—Summary of the National Health Care Act of 1975—H.R. 5000

H.R. 5990 was introduced by Congressman Omar Burleson (D-Texas). It is supported by the Health Insurance Association of America. The bill would make available voluntary health insurance coverage for most of the population through three programs: (1) an employee-employer plan; (2) a plan for individuals and (3) a plan for the poor and "uninsurables." Benefits under the three plans would be phased-in in two steps. By 1985, benefits under qualified plans would be comprehensive but until then dental and vision care, physical therapy and physical examinations need not be covered. Most benefits would be subject to cost sharing. All three plans would be administered through private insurance carriers through premium contributions. The plan for the poor and "uninsurables" would rely primarily on Federal and state general revenues. Medicare for the aged would be continued.

EMPLOYEE HEALTH CARE PLAN

H.R. 5990 provides that the employer can deduct the full cost of his premium contributions for health insurance only if he purchases a qualified plan. A qualified plan provides quite comprehensive benefits but the benefits are subject to deductible and coinsurance provisions. The employer may purchase, on behalf of his employees, an unqualified plan with a more restricted scope of benefits, but in such case would only be able to deduct, as a business expense, one-half of the premium.

The employer may offer a qualified group plan to his employees with the employees paying the entire amount. In such cases, the employee could deduct 100 percent of the premium from taxable income for income tax purposes. For a nonqualified plan, the employee could only deduct one-half of the premium. The same provisions apply to the purchase of health insurance by individuals.

BENEFITS

The benefits of the program would be introduced in two phases. Phase 1 benefits would be effective in 1977 and expanded in phase 2 in 1985.

Phase 1 benefits include: Hospitalization with no limits; medical services by a physician; the first 20 out-patient mental health visits; prescription drugs and contraceptive devices; 180 days of skilled nursing care; 270 days of home health care; use of radium or radioactive materials, oxygen, anesthetics, prostheses and medical equipment; oral surgery; diagnostic x-rays and laboratory tests performed in connection with a suspected diagnosis; well baby care including immunizations for children under age five; preventive dental care for children up to age 13; one eye refraction per year for children under 13; family planning; and one pap smear every 2 years for women over the age of 19.

Phase 2 benefits include: dental care for fillings and extractions for all ages; physical therapy; one eye refraction every 3 years; eye glasses and hearing aids; hearing examinations every 3 years; and one physical examination every 5 years for persons over age 5.

The above benefits in both phase 1 and phase 2 would be subject to deductibles, coinsurance and limitations. For most individuals, the deductible would be $100 with 20 percent coinsurance. There would be a limit of $1,000 on total deductible and copayment charges per family.

The premiums for a qualified Employee Health Care Plan would be paid by employers to the insurance carrier.

INDIVIDUAL HEALTH CARE PLAN

Individuals and self-employed persons could also purchase qualified health insurance plans. The benefits of a qualified plan are the same as for the Employee Health Care Plan. Persons purchasing a qualified individual policy could, if they itemized their deductions on their income tax return, take the entire premium cost as a medical expense deduction. Otherwise, only a 50 percent deduction is allowed.

STATE HEALTH CARE PLAN

The State Health Care Plan is designed to cover the poor and "uninsurables." The benefits would be the same as for the Employee Health Care Plan except that the deductible and coinsurance requirements would be related to income.

The State Health Care Plan would be administered by a private insurance carrier (or group of carriers) in each state and financed by premium payments related to income. Only the very poor would not be required to pay premiums. Most of the payments would come from contributions from Federal and state general revenues. The Federal share would be from 70 to 90 percent, depending upon the per capita income of the state.

The premium income of the plan would be deposited in a state insurance pool along with Federal and state receipts. From this pool, all benefits and expenses would be paid. The pool would be reinsured by all health insurance carriers licensed in the state. If the pool suffered a loss in a given year, the loss would be borne by the reinsuring carriers up to a specified maximum percent of premiums. Any additional loss would be absorbed by the Federal and state governments.

The state insurance department would be responsible for establishing the pool. A committee of five qualified actuaries would be appointed by the state insurance commission to make actuarial determinations for the pool and recommend premium rates and charges.

The bill would also make health maintenance organizations available as an option to those enrolled in the employee and state plans. These are also included provisions designed to encourage development of ambulatory health centers.

A health policy board in the executive office of the President would be created for the purpose of recommending improvements in the organization, financing, delivery and quality of health care.

The bill would also amend the Public Health Services Act to liberalize current law with respect to health manpower.

ANALYSIS

H.R. 5990 is an unabashed program to expand the market for private health insurance.

H.R. 5990 would continue the dual system of financing health care. There would be one program for the employed and individuals who can afford to purchase individual health insurance policies. The other program is for the poor and uninsurables, financed by premiums, Federal general revenues and state funds. Inevitably, fiscal pressures would develop to curtail the public program as with Medicaid. Uninsurables, those who need protection the most, would have to pay as much as twice the rate for insurance coverage as other persons.

Many people would fall between the cracks and not have health insurance coverage. Principal non-covered groups would be small marginal employers who could not afford the qualified employee-employer package or even non-qualified plans, seasonal and part-time employees and individuals with incomes just above the income level required for participation in the public program but who could not afford high cost individual policies.

H.R. 5990 follows the traditional insurance industry pattern which sloughs off high risk groups (the poor and uninsurables) on the government and reserves the better risks for itself. The bill perpetuates the vicious practice of experience rating whereby older and disabled persons, the so-called "uninsurables," would have to pay high rates for the same coverage provided to younger and healthy persons. This would lead to discrimination in employment against older workers. Under a national health insurance program, the risk of illness should be spread over the entire population. The establishment of separate risk categories only adds to administrative expense which could be better spent on health services.

The bill would be expensive to administer. Benefit payments under individual insurance policies are only one-half of premium charges. For small employers, which is the predominant group not now providing insurance coverage for their employees, insurance company retentions range from 25 to 35 percent of premiums. Were H.R. 5990 to become law, operating expenses of third parties would be substantially higher than the present 14.5 percent of premium income. In contrast, in Canada, the provinces administer their national health insurance program for about 4 percent.

While the bill provides for prospectively approved rates for hospitals and other health care institutions, the charge for services would be subject to approval by a State Health Care Institutions Cost Commission completely dominated by those to be regulated. Only 2 of 8 members would be required to be consumers.

The bill would also continue paying for physician services on the basis of usual and customary fee which experience has proved to be highly inflationary. The AFL–CIO, from the inception of the Medicare program, has pointed out that the reimbursement formula for physicians was biased in favor of escalation of costs and against adequate cost controls. Reimbursement of physicians based on "prevailing" charges and usual and customary fee is an open invitation to doctors to escalate their fees so that the new higher level of charges will have to be considered "prevailing." Better results would be obtained by contractual relationships with providers of medical care or negotiated fee schedules. There is no effective cost control under H.R. 5990.

The operation of State Health Care Plans for the needy and uninsurables would be under the supervision of the various state insurance departments. With few exceptions, these departments are sympathetic to, if not dominated by, the insurance industry. The interests of the patient-consumer are totally ignored under this proposal.

Because the insurance industry would have effective fiscal control over all funds from both the private and public sector, the implementation of national health policy would be at the industry's discretion. This is a highly ineffective method of implementing public policy in the health field. The industry would be using public funds to create a financial monopoly.

APPENDIX D—SUMMARY OF THE COMPREHENSIVE HEALTH CARE INSURANCE ACT OF 1975, H.R. 6222

H.R. 6222 was introduced by former Congressman Fulton (D-Tenn.). It is supported by the American Medical Association. The bill would establish three programs: (1) a mandated employer plan which would require employers to offer a specified private health insurance package to their employees; (2) a plan for continuation of coverage under employee plans for persons receiving unemployment insurance and (3) a plan to offer on a voluntary basis private health insurance coverage for the unemployed and self-employed. This plan would be subsidized by federal income tax credits or certificates of entitlement for those with no income tax liability. The aged would continue to be covered by Medicare but could supplement Medicare benefits by (3) above.

Benefits: All three plans would provide for a 12-month period: 365 days of hospital inpatient care, 100 days in a skilled nursing facility, medical services provided by a physician or the outpatient department of a hospital, home health services, dental care for children, (would initially be limited to children age 2–6) inpatient and outpatient psychiatric care, well-baby care, immunizations and preventive care.

There is no deductible, but all benefits would be subject to 20 percent coinsurance. The total amount of coinsurance a patient would have to pay varies with income. The very poor would pay no coinsurance. The threshold for no coinsurance would be an income below $1500 for a single person and $4200 for a family of four. A family of four with an income of $15,000 have to pay $1080 in coinsurance amounts. The ceiling on such copayments would be $1500 for an individual or $2000 for a family. After these coinsurance ceilings had been met, a catastrophic benefit would take over and pay all additional medical care expenses. The rich, who could meet the copayment requirement, would, therefore, pay a decreasing percentage of their income for further medical care.

MANDATED EMPLOYER PLAN

Every employer would be required to offer his employees the benefit package outlined above or a better one. The employer would have to pay at least 65 percent of the premium. Coverage would begin one month after employment and continue for 30 days after termination. Employers whose payroll costs are increased by more than 3 percent for the mandated coverage would receive a cash or tax credit subsidy which would be phased out over 4 years.

INSURANCE FOR THE UNEMPLOYED

A terminated employee eligible for unemployment compensation would be entitled to continuation of his or her last employer's plan. In such case, the premiums on such insurance would be paid by the federal government from general revenues.

SELF-EMPLOYED, NONEMPLOYED, AND THE ELDERLY

Medicredit principles would apply to insurance for self-employed and the nonemployed. That is, the government contribution toward the premium would be related to income. The government contribution would be made in the form of a credit against income tax or a certificate of entitlement for those with no income tax. The certificate of entitlement would be submitted to the insurer for payment of premium and be paid by the federal government from general revenues. For such persons the premium would vary with income and the federal government would pay the difference between the full premium and the income related premium that an individual or family would have to pay. The elderly on Medicare could subscribe to catastrophic coverage by paying the income related premiums.

ADMINISTRATION

The program would be administered by Blue Cross-Blue Shield and the insurance industry. At a national level, a health insurance advisory board of 15 members would be established consisting of the Secretary of HEW as Chairman, the Commissioner of Internal Revenue and at least six practicing doctors of medicine, one doctor of osteopathy and one dentist.

ANALYSIS

It is difficult to find fault with the scope of benefits of the AMA supported bill. A definite plus is that H.R. 6222 does cover preventive care. However, the 20 percent coinsurance provision would mean a $3 charge to the patient for a $15 office visit to a physician. This would be a signicant deterrent to many people in seeking diagnosis and treatment of a condition that showed mild symptoms.

The bill would pay for any care the doctor ordered. Physicians would, therefore, have almost unlimited power to expand their incomes by utilizing the most costly methods and techniques of diagnosing an illness. The same considerations apply to treatment methods as well.

The prohibition in the bill forbidding interference with the practice of medicine simply means that the physician can be as extravagant as he pleases and he has every economic incentive to be extravagant.

Significantly, the AMA-supported bill has no provision for either cost or quality control.

Nor is coverage universal. While the employer must offer a health insurance plan to his employees, participation in the plan by individual employees is voluntary. Since employees may be required to pay 35 percent of the premium, many would take a chance and defer participating. Also, participation in this plan for the self-employed, the non-employed and the elderly is entirely voluntary.

The cost of administering the income related coinsurance provisions of the bill would be very high. Employees working for small employers and all individuals not covered by a group policy would have to pay 25 percent more for their insurance than the average group rate for large employers.

There would be no role for consumers under the bill except to pay taxes, premiums and coinsurance bills.

APPENDIX E—CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM ACT OF 1975, H.R. 10028

The Catastrophic Health Insurance bill introduced by Congressman Waggonner (D-La.) includes three titles. Title I establishes a Catastrophic Health Insurance Program which covers all residents of the United States. Title II establishes a Medical Assistance Plan for low-income individuals and families with eligibility being based upon an income test ($4800 for a family of four). Title III establishes standards for group and individual insurance policies which are to be offered to the general population not eligible for the Medical Assistance Plan for the poor.

TITLE I—CATASTROPHIC HEALTH INSURANCE PROGRAM (CHIP)

Benefits

Same kinds of services as provided under Medicare Parts A and B. There would be no upper limitations on hospital days or home health visits. Medicare's limitation on skilled nursing home care of 100 days would be retained. That is, the catastrophic benefit would not cover skilled nursing home care in excess of 100 days. Mental health benefits would be more generous under the bill than under Medicare. The catastrophic benefit would provide unlimited outpatient and inpatient mental health services in an institution or community mental health center, but only five visits to a privately practicing psychiatrist during any twelve-month period unless approved for more visits by a professional review organization.

Deductibles and copayments

The first 60 days of hospitalization are excluded. Medical benefits are subject to a deductible of $2000.

TITLE II—MEDICAL ASSISTANCE PLAN FOR LOW-INCOME INDIVIDUALS AND FAMILIES

Coverage

All persons whose income falls below the following levels would be eligible: $2400 single person; $3600 two person family; $4200 three person family; $4800 four person family (plus $400 for each additional family member).

There is no asset test. There is a "spend-down" provision which provides that families with incomes higher than the above levels would become eligible when their medical expenses reduced their income down to the eligibility level.

Benefits

The benefits are designed to complement the catastrophic program. Hence, Title II would cover the first 60 days of hospitalization and medical expenses up to $2000 when the catastrophic plan takes over. The deductible and coinsurance payments by low-income Medicare patients would be paid by the government as well as the Part B premium.

Long-term care in skilled and intermediate nursing home facilities would also be covered. Single persons without dependents would have to pay all of their income over $50 per month to the intermediate nursing home. They would retain the $50 for personal expenses.

In place of deductible and coinsurance payments, low-income beneficiaries, other than Medicare beneficiaries, would have to pay $3 per visit to a physician for the first 10 visits except that no copayment is required for well-baby care, family planning services and periodic screening examinations for children under the age of 18.

TITLE III—BASIC PRIVATE HEALTH INSURANCE VOLUNTARY CERTIFICATION PROGRAM

Private group and individual health insurance policies would be certified by the Secretary of Health, Education and Welfare, if they met minimum standards.

Basically, insurance carriers would have to offer a minimum benefit package to complement the catastrophic program in order for their policy to be certified. This minimum package would have to include:

1. Hospitalization for the first 60 days: no deductible could exceed $100.
2. Medical coverage up to the first $2000 of medical expense with coinsurance requirements not to exceed 20 percent of reasonable expenses and with a $50 per person per year limitation on deductibles.
3. Exclusions and waivers of eligibility in individual policies not to be allowed except for pregnancy. There could not be any waiting period prior to the beginning of coverage for group policies and not more than 90 days for individual policies.

Such policies would be offered but there is no requirement that employers would have to purchase them on behalf of their employees nor would individuals be required to purchase them. Title III is entirely voluntary.

Financing

The catastrophic program would be financed by a 1.0 percent tax on employer payrolls and self-employment income. Employers and the self-employed would receive a 50 percent tax credit against their one percent tax liability. Employers opting for private insurance would have the amount of their premiums deducted from their one percent tax liability. They would also be eligible for the 50 percent tax credit on both the total amount of premiums paid for catastrophic insurance and any remaining federal payroll tax liability after the premiums have been deducted. This amounts to an effective tax rate of 0.5 on employer payrolls. The low-income program would be financed from general revenues.

Administration

Titles I and II would be administered by the Social Security Administration using Medicare intermediaries and carriers. Employers opting for private catastrophic insurance could elect their own carrier.

ANALYSIS

H.R. 10028 is a bill to help only the poor and the rich. For the great majority of middle-income Americans, the bill does very little.

Basically, the bill is not a national health insurance plan at all since the population would only be covered for catastrophic medical expenses. Only the poor would have protection for routine medical expenses below $2000, and hospital coverage for less than 60 days.

The bill does federalize the Medicaid program and liberalizes it in some respects but eligibility for the program is restricted by an income test which is substantially lower than is required by many states under their existing Medicaid programs. The income test for low-income individuals and families means a denial of health care as a right as they would have to declare themselves impoverished.

Title III of H.R. 10028 does nothing to improve basic health insurance for most of the working population. Insurance companies would have to offer a minimum benefit package but they have been offering better plans than the minimum benefit package required by the bill for years. The only problem is that too few small employers could afford to buy them. The catastrophic bill would not help employers or individuals in buying more comprehensive policies.

Low-income individuals who earn slightly above the poverty level and who could heretofore not afford to purchase an adequate health insurance policy still would not be able to afford it under the bill.

The insurance companies have never sold much health insurance with reasonably comprehensive coverage. Voluntary health insurance under the catastrophic bill would continue to emphasize the payment of expenses related to in-hospital costs. Private health insurance policies place no emphasis on preventive health care.

More than one-fourth of the civilian population under 65 do not have coverage of X-ray and laboratory examinations outside the hospital. Half the population has no coverage for physician visits in the home or office. About half have no coverage of prescription drugs outside of the hospital. The catastrophic insurance bill would do nothing to improve these Americans' access to care.

Benefits under the Catastrophic Health Insurance Program do not cover skilled nursing home care, a surprising omission. Medicare patients who might exhaust their entitlement to post-hospital extended care of 100 days would not be eligible for catastrophic benefits. If such a patient had remained in the hospital, his hospital bills would be paid by the catastrophic program without any limit. Moreover, an insurance carrier need not offer skilled nursing home care in its benefit package as a basic requirement to be certified by HEW under the voluntary health insurance program. Only those eligible for the Medical Assistance Plan for Low Income Individuals and Families would have coverage for skilled and intermediate nursing home care.

Neither is preventive care a required benefit under Title III, in order for a private health insurance policy to be entitled to the seal of approval by the Secretary of HEW. Title II, the medical assistance plan does not cover preventive care for adults over the age of 17.

The total emphasis of the program is not to prevent illness but only to pay for acute care in the most expensive way—in the high cost hospital. In fact, the bill specifically provides that Title I, the catastrophic plan, would pay in addition to any other public or private health insurance policy that the seriously ill patient might have. Such a double payment gives both the doctor and hospital every incentive to hospitalize and overtreat as even exorbitant bills would be fully covered.

After experiencing the cost escalation that occurred after the passage of Medicare, the catastrophic proposal would simply amplify the Medicare experience with its escalation in cost.

The ineffective cost control provisions of Medicare would be continued. Hospitals would be reimbursed on a cost basis and physicians would be paid their usual and customary charges. Doctors would not have to accept their customary fees in full payment for their services except for those covered by the low-income plan. The catastrophic bill is an invitation for cost escalation, not cost control.

The cost of administration of the bill would be horrendous. The cost of administering the income test to low-income individuals and families would be at least 25 percent of benefit payouts. The spend down provision is especially difficult to administer since it is impossible to know who is and is not eligible for the program at any given time. In fact, it is likely that Title II is unadministrable.

Built into the catastrophic plan is a costly rip-off for the insurance industry. This results from the provision that the employer receives the same 50 percent tax credit against the 1 percent payroll tax whether or not he elects to be insured by the Social Security Administration or by a private carrier of his choosing. Because of this tax credit, the employer has no incentive to bargain with the carrier over premium rates. The only control would be an "actuarial" table of values which would be submitted by an Actuarial Committee in HEW. Health insurance benefits equal the premiums collected less administrative costs. Actuarial calculations are unnecessary. Insurance companies make their money by building actuarial risk factors into these premiums. These risk factors are just disguised profits.

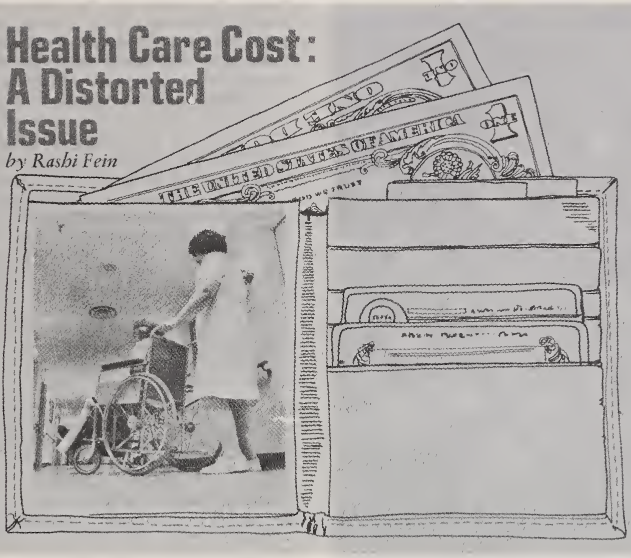
The bill accepts the present unstructured nonsystem of health care delivery and provides no incentives for rationalizing the delivery of health services.

The bill would have no impact on alleviating the health manpower shortages nor about redistributing physicians from areas that are over-doctored to areas that are under-doctored. To the contrary by emphasizing the highest cost care, it is likely to have just the opposite effect.

The catastrophic proposal does nothing to increase the supply of primary physicians (general practitioners, internists and pediatricians) who provide care for 90 percent of routine illnesses and nothing about the overabundance of superspecialists and surgeons to take care of rare conditions. In fact, the catastrophic insurance program will result in a neglect of preventive and day-to-day care, thereby guaranteeing more catastrophic illness and more superspecialists. Thus, the bill is the antithesis of what a good health program should be.

Health Care Cost: A Distorted Issue

by Rashi Fein


THE UNITED STATES OF AMERICA
ONE
TWO
IN GOD WE TRUST

All of us who believe in national health insurance because it is comprehensive, universal, fair and equitable are asked one question: "What will it cost; can we afford it?" Some really wonder, and we owe them an answer. But others are asking not because they really wonder but because they want to muddy the waters and cast doubt. They are not interested in an answer; their problem is they know the answer—and just don't like it.

There is an element of dishonesty in some of the language, questions and issues raised by some who oppose national health insurance. Honest men and women can disagree about a number of issues involving national health insurance. We can and should debate matters relating to financing, to private and public mix of funds, to ways of paying for services. There is a lot, legitimately, to argue about.

Nor do honest men and women all understand the issues of cost perfectly. But some who do understand the issues correctly use scare tactics about cost to confuse the public. They do not believe their own testimony before Congress, but they hope the public will believe it. We ought to recognize that for what it is and turn our attention to the real task before us—explaining the issues to the American people.

What is the story of costs; what can we afford; what is national health insurance all about in dollars and cents? It may be useful to remind ourselves of the situation as it is today and to consider the situation as it will be when national health insurance is enacted.

We are spending over $100 billion a year in the health sector today. In fiscal 1974, the total was $104 billion, and $97 billion of that was for health care and supplies with the remainder for research and construction. That was money spent—dollars transferred from individuals, insurance companies or government to the health sector, to providers of goods and services. There is an ongoing health activity. It employs over 4 million persons, provides over a billion physician visits and about 250 million hospital inpatient days per annum. The health sector is alive and thriving—at least as measured by the dollars flowing into it, 7.7 percent of the gross national product. It is inefficient. It wastes resources. It fails to deliver care to large numbers of people who cannot afford to pay for services or who do not find services available when and where they need them. But it exists; it is financed; it utilizes resources.

We feel the nation should be getting more than we are for the $100 billion. We should, but that is not my point. What is important for the moment is that there is a $100 billion industry out there. We are not talking of creating a new enterprise—a new health industry—when we speak of national health insurance. It is not as if we have nothing today and want to create 350,000 doctors, 1.5 million hospital beds and all the rest and pay for it. We are not an under-

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developed country without a health care system engaged in a great debate over whether to invest scarce resources in developing personnel and facilities. We already have a system—a $100 billion enterprise.

All that is important because it lies at the heart of one of the significant differences between national health insurance and other proposed government expenditures and programs. It is at the heart of the discussion about costs and what we can afford.

When government spends money for new desks and chairs, for parks or dams, for the CIA, this represents a change in the way resources are allocated in the economy. In those cases, government pays for things that were not going to be paid for by the private sector. When government builds or pays for a dam, it does not ask whether government should pay for a dam or whether individuals should buy it on their own. It asks, instead, whether we should have a dam at all. And it adds a constraint: if we say "yes," it means we will have to do without something else. To ask "should we have a dam" is to ask a meaningful question—for, if government authorizes a dam, it is a new dam that is created. If government puts new money into new programs that deliver services previously not available or delivered, we are talking about new services: parks, roads, inspection, regulation and so forth. New services require new resources—resources that could have been used for other things in the public or private sector.

If, on the other hand, government talks of assuming the costs of services already being delivered and paid for by the citizenry—as is the case with health services—there are no new total dollars or total resources involved. Every dollar government spends on health relieves us, the public, of dollars that we would have spent on health.

There is, of course, a new and different financing mechanism, a new way of spending old dollars, but that is not the same as new dollars. New parks, roads or bombers represent money for things the people would otherwise not have. But medical care is different: we are already spending $104 billion, and private expenditures account for $63 billion of that total.

So the issue is a non-issue. The question can we, as a people, afford national health insurance really means can we afford to spend what we are already spending—and surely the answer is "yes." The issue is not whether we are spending more than we can. The issues are whether we are getting what we should for our money and whether the present arrangements which make health expenditures depend on a family's income are fair, just and humane.

But, the critics say, what about those people who today cannot afford to purchase medical care. Won't national health insurance cost more than we are now spending when it attempts to provide care to those who today find price a barrier? They ask whether we can really afford a universal national health insurance program that brings health care to the forgotten and the rejected Americans? What does that really mean? Anyone who asks those questions apparently believes that we do not have enough and cannot produce enough medical care services—and that is untrue—and, rather than alter, modify and improve the health care system, prefers to continue rationing health care on the basis of ability to pay—and that is unjust.

In part, of course, the critics say they agree, and that is why they contribute to charity and "support" Medicaid. But, of course, to the extent that charity and Medicaid do purchase health care we are back at square one, talking about dollars that are already being spent. In our view, national health insurance is fiscally a substitute for, not an addition to Medicaid, but it is also different from and better than Medicaid. It is a better way of spending the dollars that are already being spent. No, the reason some of our critics may prefer even Medicaid to national health insurance does not relate to the total dollars going for care. The real reason is some people like the Medicaid system—not because it is efficient, just, humane and decent—but because they feel it is an appropriate system for those whom they consider undeserving. Their chief complaint about it is not that it is a demeaning system in which people are required to trade their dignity for some health care. Their chief complaint is that we are spending too much on it. And when they say, "we are spending too much," they do not mean America cannot afford it. They really mean, "why spend that much on people who aren't making it on their own?"

The fact is that even with Medicaid and other programs, too many Americans still receive inadequate care. National health insurance will permit them to enter the medical care system and will require resources for their care. That is good. That is what we want. That is one of the important reasons we favor the Health Security Act. I am not ashamed of being in favor of decency, humaneness and justice. I am willing to spend dollars, new dollars, to achieve it. In fact, however, I am convinced that we can have a well run system of health care that, by eliminating present waste and inefficiency, can provide care for all the people with fewer resources than are now providing care for only some of the people. For $100 billion we can provide for all 213 million Americans. But even if our critics disagree, even if they argue it will cost more than we are now spending, what would they have us do, continue to deny care to those who need it but cannot pay? Do they really mean we cannot afford it, or do they mean that they prefer not to concern themselves with the problems of the less fortunate?

Unemployment is costing our economy billions upon billions in dollars—aside from the human suffering. Yet we are told the nation cannot provide health care for its people. If we did not have public education, they would tell us we could not afford that either. If we did not have unemployment compensation, they would tell us we could not afford that—or social security or higher education or workers' compensation. Their economic policies cost the nation tens of billions of dollars in lost wages and products and untold human suffering, yet they ask us whether the nation can afford national health insurance.

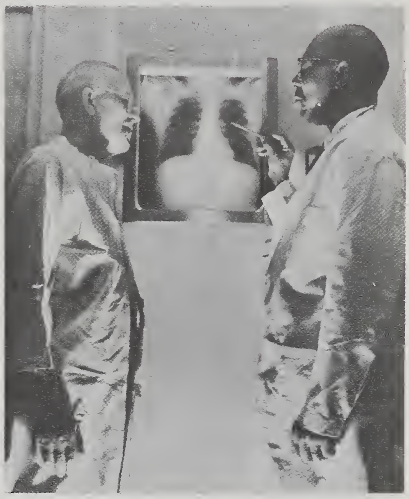
Yet another argument is used: if government pays for medical care, it is said, you and I will attempt to get more care than we need. We will flood the hospitals and the doctors' offices, inundate the system and bankrupt the economy. But where is the evidence that we are all so in love with medical care that we will face waiting time, travel costs, absence from work, fear and concern to behave that way? The evidence is not found in prepaid group practices where monetary barriers to care have been eliminated or reduced. It is not found in outpatient departments because they have to mount outreach and follow-up programs to get people to use the services. It is not found in the experience of other nations. Canada can manage to meet its commitments but we, presumably, would be unable to meet ours.

This is the rationale offered for coinsurance and deductibles—for that which is so pleasantly called "cost sharing." Cost sharing is supposed to make you and me behave responsibly, but the real issue is how to induce the system to behave responsibly. You and I do not decide to order unnecessary lab tests; we don't really make the decision that we would like to enter or stay in hospital an extra few days; we are not out there balancing prices and satisfaction and deciding whether we prefer another $10 worth of care or something else. The bulk of those decisions are made for us. High cost sharing is not consistent with the goals and aims of a comprehensive, universal and equitable national health program. Low cost sharing —and that which is low for some is high for others—is not worth the administrative costs. Those who are so concerned about costs might want to join us in eliminating the unnecessary costs involved in administering a system of deductibles and coinsurance. Moving billions of pieces of paper around is expensive—that is waste and, therefore, is something we cannot afford.

At the margin, and for the poor the margin is narrow indeed, price does make a difference. But will the system go bankrupt without price barriers? The U.S. Department of Health, Education and Welfare—a department not known for its support of Health Security—has estimated that the difference in total expenditures—total dollars spent on health, whatever the source of the expenditure—between the Health Security Act and the Administration bill introduced in the last Congress was $6.5 billion on a total estimated expenditure of about $123 billion. We believe that is a substantial overestimation of the costs of the Health Security Act. Among other things, it fails to take account of the very real savings that will come about because of system changes that are part and parcel of the Health Security Act. The HEW estimates assume that the Health Security Act will only finance care and not change the delivery system, and that is not what Health Security is all about. Nevertheless, even HEW admits that the Health Security Act—even without system savings—would add only 10 percent to what the nation will spend if no legislation were enacted and only 5 percent to what the inadequate Administration bill with cost sharing would cost.

Consequently, we are prepared to argue we can afford a Health Security Act and to argue further that with system change the Health Security Act will save, not cost the nation money. There is surely more than 10 percent waste and inefficiency in the present system.

Is the argument really about going bankrupt because of an additional expenditure of some $6 billion? Can anyone say that a trillion dollar economy cannot afford the Health Security Act? The argument is not really about total dollars and total costs but about where the dollars come from and where they will go. That is the real explanation for the cost sharing and also for the mandating proposals that have been offered by the previous Administration. Requiring that patients pay out of pocket or that employers make health insurance available to their employees is not really cheaper—it only looks that way in terms of federal funds. The dollars all stay in the private sector with mandating, and government does not enter the picture. The dollars are not greener nor are they fewer. But they are private; not public. That is the real issue, and that issue is real because the Health Security Act has a social insurance approach—and it is there for a reason. The fact of the matter is that in health care private financing, operating with private-insurance principles, has not met the problems of the people. We needed social security. We needed Medicare. We got them because those who fought for those programs understood the basic issues involved. The same issues lie at the heart of the fight for national health insurance.



Keeping things substantially as they are or building upon a weak foundation will not lead to universality or equity. The Administration's bill, after all, would transfer only about 5 percent of total costs from the private to the public sector. This is what they call national health insurance—the Federal Trade Commission ought to look into that kind of mislabeling. Is it not equitable to have low-income employees spend a higher proportion of their income on health care via coinsurance, deductibles and premiums that are fixed amounts and do not vary with income or with payroll. It is not universal to have a multiplicity of plans into which people must be sorted. And in dollar-cost terms all this would increase administrative costs. Whatever they may say about the Health Security Act, at least they must admit that its dollars would go for health care and to the health system—not on paper work and to accountants.

In a March 1975 editorial, the Washington Post suggested Congress should examine the true costs of government programs—not just the costs to government, but the real costs. It said: "The argument over health care provides a classic example of the way the present system works. Health insurance plans before Congress are usually discussed in terms of how much they will cost federal or state governments in tax money. While these figures are of obvious importance, the true cost of any such plan must include the additional expenses the plan will impose on employers and employees. If those additional expenses are paid by the employers, they will be reflected, sooner or later, in prices. If they are paid by the employees, they will be reflected in a loss of buying power. In either case, they are real costs, just as tax increases are real costs.

"In order to get a true picture of the full costs of a health plan or noise reduction regulation or any other federal program, Congress needs an 'economic impact' statement not unlike the environmental impact statements now required of many construction programs. Then it could know how much a particular program or set of regulations really costs."

It surely would be advisable if the Administration prepared economic impact statements such as the Washington Post calls for. We who support the Health Security Act would welcome honest analyses—we have nothing to fear and much to gain from public information and understanding. Social legislation—Medicare, national health insurance—is never harmed by public understanding. It is misinformation that is harmful.

Actually, since the federal Office of Management and Budget (OMB) has not been doing what the Post calls for, proponents of Health Security have done it for them. That is why we know that, in largest measure, the Health Security Act is fiscally responsible. Its economic impact is in terms of equity, not total expenditures. It calls, not for an increase in real costs but, for a shift, a transfer, in expenditures—a shift that is needed and a transfer we can afford. It calls for a social insurance approach.

Thus it follows that the argument that the economy cannot accommodate itself to national health insurance, that it represents an increase in total expenditures and that we have to put national health insurance on the back burner because it is inflationary is false and deceptive. It is an argument without merit, and it does not become any more persuasive when we are told there is no such thing as a free lunch. There isn't, and we know it. But this is a lunch that is already being paid for. In fact, if the Health Security Act were passed and signed into law and if the people who administer it believe in it, the changes in the health care system and in its financing would enable us—for the same money—to have a fine dinner instead of a blue plate lunch.

Recently we were told that the President would veto a national health insurance bill even if spending were delayed a year because enactment of a spending program would encourage an inflationary psychology. If we place the facts before the public and the issues are recognized for what they are—if the public is not misled—no inflationary psychology need result. There are no witches out there, and it is less than honest first to keep frightening us with the imaginary demon of inflation and then to tell us we cannot have national health insurance because some people believe the stories of demons and witches.

Government expenditures on health will go up under the Health Security Act—that is a design feature, not an unfavorable side effect. But private expenditures on health will go down. That is also a design feature. The Health Security Act will be financed out of new revenues which can be obtained in an equitable manner and which all of us will find ourselves better able to pay, in part because we will be saving what we are now already spending on medical care and health insurance and in part because of the growth in tax revenues resulting from the turn around and expansion in the economy. We do not argue that Health Security should come at the expense of other social programs in education, manpower training, income maintenance; we can finance Health Security because we are already financing health care.

Indeed, if people want to talk about inflation, we can respond positively. It is the existing organization and financing of health care that—in the absence of legislation—would continue to contribute to inflationary pressures in the future. The real issue is whether we can continue to afford the waste and inflation inherent in the present system of care and finance. Inflationary pressures, conversely, can be contained and moderated by the kind of responsible intervention that is embodied in the Health Security Act. When it is said that it is automatically inflationary for dollars to be transferred through government back to the private sector for health care, we can respond: "Whose administrative costs are less, the Social Security System which handles Medicare efficiently or the private health insurance sector whose administrative costs are often higher than that of government?"

And so national health insurance is within our means. We are not so poor that we cannot afford one of the hallmarks of a civilized society—the right to health care regardless of income. When all the myths are dispelled, when all the rhetoric and testimony and analyses are over with, we are left with the crux of the matter—the argument about justice for all. Make no mistake about it—the guts of the issue is not about dollars. Those who opposed the Social Security Act, disability insurance or Medicare were not really arguing about money but about how the pie is shared. And the same is the case with national health insurance. The real question is whether resources shall be allocated so that everyone receives his fair share in a system in which the use of medical care is related to medical need, or whether we shall continue, as in the past, to ration care on the basis of income. The answer will be in favor of justice and decency, in favor of national health insurance. A bill will be enacted and will be signed into law.

We must recognize, however, that enactment of a law is only the beginning of a process and not the end of it. The law must be administered. Because we are concerned about cost—about saving money in the health field so that we can devote resources to other social uses, since medical care is not the only unsolved problem on the American agenda—and because we are concerned about equity, all of us will be required to make certain the legislation is administered effectively. Only public vigilance can assure that.

No one will "give" us national health insurance—not the experts or Congress or the Office of Management and Budget. The battle for national health insurance is first a battle for public understanding. Social legislation is not enacted because of the goodwill of special interest groups, but over their opposition. It is not enacted because a few legislators are concerned but because many legislators who would rather sit on the fence find that the pressure of concerned citizens makes fence sitting uncomfortable. We will not convince OMB or the American Medical Association, but we can convince the public.

Thus far, at least on issues of cost, the people have been confused. We have not won the battle of public understanding against those who have sown the seeds of public confusion. I believe it can be won because the facts are on our side. However difficult it is for facts to prevail in a struggle against deception, if enough people work hard enough at it, the public will recognize truth from error. Then, having won the battle of understanding and organization, we will have national health insurance.

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Mr. ROSTENKOWSKI. I want to thank you for an in-depth statement I want to share your hope that this is your last appearance before a congressional committee on health insurance.

Mr. MEANY. I have Mr. Seidman with me, and Mr. Biemiller, whom I am sure you know.

Mr. ROSTENKOWSKI. He is quite active.

Again, I join you in hoping this is one of your last appearances with respect to national health insurance.

I want to ask you: In polls taken on the American public's view of legislature priorities, national health insurance does not usually appear at the top of their priority listing.

I am wondering what would you judge as being the reason for it not being considered one of the top priorities in legislation?

Mr. MEANY. I don't know. I don't know how these questions are framed by the pollsters but from the reports that we get from our people, it is increasing now. This may not be No. 1, but I think it should be. But, of course, we have got an economic situation where there are millions of people unemployed. There are a lot of other things.

In fact, the first thing people are interested in is food and a place to sleep. This may be a priority at this time, but I am sure that this whole question of health care and its delivery is really way up at the top of the priorities of the American people.

Mr. ROSTENKOWSKI. Well, I am sure you are aware of the movement of Government usually, in years like 1968, 1972, 1976. There is a little more activity from both ends of Pennsylvania Avenue. I am hoping that maybe next year, 1976, with the Presidential campaign taking place——

Mr. MEANY. I attribute it to leap year.

[Laughter.]

Mr. ROSTENKOWSKI. I wondered, Mr. Meany—certainly, any national health insurance program will result in an increase of billions of dollars in the Federal budget.

Do you see this as a political problem as well as a fiscal problem?

Mr. MEANY. I think that anything that directly affects the lives of practically all the people in the country certainly has a political aspect to it. I am sure that people down at the lower end of the economic ladder would like to see a system where they would be assured of adequate medical care, and certainly that is the position that we take, and I am sure there is a political aspect to it.

Mr. ROSTENKOWSKI. Well, in most instances, Mr. Meany, people don't realize the need for national health insurance until it strikes them and their family, and I certainly agree that those people in the lowest economic structure, that the Government should provide for them.

Mr. Duncan will inquire.

Mr. DUNCAN. Thank you, Mr. Chairman.

I would also like to welcome Mr. Meany and your staff. You are always helpful whenever you appear, and we appreciate your taking your time to give what I think is a great input into these hearings.

You mentioned that you were here 4 years ago, and, in fact, we were talking about national health insurance 6 and 8 years ago.

Do you not think that one of the reasons that we don't have some form of national health insurance today is because every proponent thinks that his plan is the only one, and will not sit down and try to compromise with other people?

In fact, I think Senator Kennedy saw that last year when he left Mrs. Griffith on the Kennedy-Griffith bill and joined Mr. Mills. But if we keep saying that our bill is the only one, I don't think you will ever have national health insurance.

Let me ask you first. Don't you think we would be better off to start with something and build? If we had started 6 years ago, we might have a pretty good program today.

Mr. MEANY. I think that this room and this building we are in is certainly the result of a philosophy that calls for compromise of some kind. We come here and we say what we think about health security, and we think it is the best, but I am sure that we would be willing to sit down and talk about something else. But we are making our case, and I am sure the insurance companies will make their case.

Mr. DUNCAN. I am pleased to hear you say that.

Mr. MEANY. Certainly, when you get down to writing the bill, we would certainly like to talk about it, but the time for compromise is not when you are testifying here today. [Laughter.]

Mr. DUNCAN. I understand that, but in the past, nobody wanted to compromise, and I am pleased to hear you say that. You are willing, because others seem to be wedded to their proposal and nowhere else do they wish to go.

Do you think that the workers are willing to bear the expense of such a program as you advocate by payroll deductions?

Mr. MEANY. Well, it is built into the American system, payroll deductions, you know. I started out advocating payroll deductions in order to sell Victory bonds for the Treasury Department 30 years ago, and we still have a system in many plants throughout the country that has continued all these years. This is part of the system. It is the way that you provided for the future. This is part of unemployment insurance, where a fellow works an hour and into a pot goes some money. It is for a later contingency. It is a payroll deduction.

I am sure that those down at the bottom of the economic ladder will certainly be glad to pay for this payroll deduction.

Mr. DUNCAN. We find a lot of those people today, though, are complaining because too much is being deducted in social security and other matters, and if we add another tier on top of that, you wonder whether it would be acceptable or not.

Mr. MEANY. Mr. Seidman would like to comment on that.

Mr. DUNCAN. I would like to hear Mr. Seidman.

Mr. SEIDMAN. The health security bill, H.R. 21, does not provide for any increased payroll tax for employees over and above approximately what they are now paying for medicare.

In other words, what they are now paying for medicare under H.R. 21, would be used for the health security program. There would be additional financing over medicare, obviously, under the health security program, but there would not be an additional payroll tax on employees.

Mr. DUNCAN. Mr. Wilbur Cohen, when he testified before the committee, and I suppose you might call him the architect of the medicare and medicaid program, he cautioned the committee, which some of us were rather surprised at, that we should not move with haste on a program, because it could not be implemented for 3 or 4 years, and that we should move slowly and put it on a firm foundation.

What are your views along that line, Mr. Seidman, or Mr. Meany, either one?

Mr. SEIDMAN. To some extent, I agree with Mr. Cohen. We would agree with him that it is the kind of a program that requires a tooling up period, and the bill, as a matter of fact, does provide for a tooling up period of a couple of years or more after enactment before it would actually take effect. If that is the kind of thing that Mr. Cohen has in mind—I didn't hear him—I think we would certainly agree with him.

On the other hand, we are not—we don't think that, starting, let's say, with hospitalization and then moving to ambulatory care, or vice versa, is a very effective way of getting control of the costs and quality of the health delivery system.

Experience of other countries has shown that that kind of approach is self-defeating.

Mr. DUNCAN. What percentage of the increased cost of health care do you attribute to labor and hospital costs on matters that the physician actually has no control over?

Mr. SEIDMAN. I would say that very little of the increase in costs results from factors that the physician has no control over. Some of it, the physician doesn't have total control over, particularly some of the decisions that are made by the administrators and boards of trustees of hospitals, which result in increased hospital costs.

As far as the increase in labor costs is concerned, the figures of the American Hospital Association show that if you take labor costs as a percentage of total hospital costs, they have not been going up. That is, the nonlabor costs of hospitals have been rising at about the same rate as labor costs, and this is despite the fact, and we are not the least bit ashamed of this—we are quite proud of it—that low-paid hospital workers are at last beginning to get a decent break, that they are now covered by collective bargaining, and that they are covered by the minimum wage.

Mr. DUNCAN. How can you say that labor costs aren't going up? Because the information that we have had supplied to the committee is that costs are beyond the control of the physician—labor and hospital costs—run about 40 percent of the recent increase in the cost of health care.

How can you say that labor costs are not going up?

I am also glad to see it, because hospital workers are certainly underpaid.

Mr. SEIDMAN. I am sorry. I guess I didn't make myself clear. I didn't mean labor costs have not been going up in an absolute sense, but in proportion, they have not been going up. If labor costs had been rising at the same rate as increased hospital costs——

Mr. DUNCAN. My time is up, that is all. Thank you.

Mr. ROSTENKOWSKI. Mr. Corman will inquire.

Mr. CORMAN. Just a comment. The first time I heard you testify, Mr. Meany, was 12 years ago. You were advocating something that seemed absurd to some, and it was that there should be racial justice in this country. Thanks to you, and Chairman Celler, and others, we have moved a long, long way in that area. I think Mr. Rostenkowski is about to play the role in health that Chairman Celler played in equal rights.

Thank you for being here.

Mr. ROSTENKOWSKI. Thank you for your confidence.

Mr. Cotter will inquire.

Mr. COTTER. Thank you, Mr. Chairman.

Mr. Meany, on pages 3 and 4, you state that we are also spending over a hundred billion dollars on health care today.

Now, the estimates we have for the cost of the Kennedy-Corman approach would be from $118 billion to $127 billion.

What concerns me is where the money is going to come from. I was wondering if you could elaborate on that statement.

Mr. MEANY. Well, we have taken a position that you are going to spend the same amount of money that you are now spending. If we are wrong, I would like somebody to show me.

Mr. COTTER. Could you elaborate on if for my edification?

Mr. MEANY. What do you mean elaborate on it? It is what our figures show.

Mr. COTTER. We are spending $118 billion, according to your figures, on health care today, is that correct?

Mr. MEANY. $118 billion, I think, is the figure.

Mr. COTTER. $118 billion, and you say if we institute a national health insurance with increased benefits, it won't cost us any more because we are spending?

Could you give me the breakdown?

Mr. MEANY. Yes, we can give it to you, yes.

Mr. SEIDMAN. As you know, Mr. Cotter, the Department of HEW puts out figures every year showing the breakdown of national expenditures.

The point that Mr. Meany is making is that we are not talking about any new health expenditures. We are not talking about creating a new health delivery system. We have a health delivery system. We are not an underdeveloped country which is talking about putting in a whole new health care system. We have it already. This is not something which would involve expenditures for new or additional things. It is essentially a way, in the first place, of redistributing the costs of what we are already spending, and secondly, and this is very important, beginning to put some controls on it through a global budgeting system.

Mr. COTTER. Is your position that the Kennedy-Corman bill, if enacted into law, will cost no more than we are spending today?

Mr. MEANY. That is what our research shows, that we are spending this $118 billion, and that this bill would not add to it, no.

Mr. COTTER. I find that hard to believe.

Mr. MEANY. Well, that is life. [Laughter.]

Jim Schlesinger picked up the newspaper the other morning, and he found something that was hard to believe, too.

Mr. COTTER. Here we are going into programs that expand availability of service, and you contend it won't cost any more. I just can't believe it.

Mr. SEIDMAN. I think you are not taking account of the fact that we have many unnecessary services today which the health security program would control. If we had ambulatory care available to every American, as we do not today, far fewer people would be going into hospitals. Far fewer people would require surgery, because we would catch illness at the early stages. Instead of focusing on the most expensive part of medical care, the care that goes on in the hospital, we would, indeed, put our emphasis on preventive and ambulatory care, which is the less expensive type of care, which, if it is applied, will prevent us from having to spend the large amount of money that we are spending today.

Those are the kinds of cost controls that are built in the health security system that we do not have today. There are others as well. That is one reason why, when the program starts out, it would cost no more than the present system does, and as time goes on, it would cost much less than the present system would in future years.

Mr. COTTER. I believe in preventive health care, and I think it is something which we have got to look into and put into effect, but initially, to set up a system of preventative health care is going to cost a great deal of money, and before you begin to derive the benefits from it, you have a time lag, which has got to cost you a lot of money.

Mr. SEIDMAN. The health security bill provides, as you know, for a health resources development fund, which is intended to provide funds for the kind of services you are talking about, and this would come out of the resources of the program.

Mr. COTTER. Thank you very much.

Mr. ROSTENKOWSKI. Mr. Crane will inquire.

Mr. CRANE. Thank you, Mr. Chairman.

I, took, would like to welcome Mr. Meany and my good friends, Mr. Biemiller, and Mr. Seidman, to the committee.

I, too, Mr. Meany, hope this is your last appearance with respect to national health insurance, but for different reasons than our distinguished chairman.

I commend you for being a very effective adversary. I wish some of those on the other side of the debate would take your position that this is not the place to compromise; namely, before the committee, in making a presentation.

There are a couple of questions that come to my mind. One is your seeming faith that a Government monopoly health care system would result in efficiencies. I do know the figures you quoted, but on the other hand, I am sure you have seen the Vogel-Blair study that HEW commissioned to study Government health care programs, the Blues, and for profit insurers.

Mr. MEANY. We have material on that, and we think we can document our point on that.

As far as the present system is concerned, and you talk about costs, the way the costs are going on the present system, it will be completely out of range unless Government does something about it.

Mr. CRANE. I think there are two potential flaws in that argument, though, with due respect. One is to lump the Blues with the for-profit insurers, because that was the distinction that Vogel-Blair made. The pro-profit insurers were bound to be more efficient than either the Blues or the Government.

A second point that I am concerned about in your presentation is your suggestion that the national costs for health care will be the same as they are now. You are presumably going to try to rearrange them so that the money spent for health care will be more judiciously spent by the Government than under our present system.

But in light of the British experience or, say, the Swedish experience, that hasn't been the case.

Mr. MEANY. We don't want to emulate the British or the Swedes.

Mr. CRANE. I can understand why.

Mr. MEANY. The most comparable system to the one we are talking about would be the Canadian and not the British.

Mr. CRANE. We had testimony from British, Swedish and Canadian witnesses, and someone put the question to all of them about the advisability of our seeking to emulate their respective systems, and none of them thought that that was advisable. There was another common denominator, I think, in their testimony, and that was the advisability of a pluralistic system incorporating a mix of public and private care.

Mr. MEANY. Did any of these witnesses represent workers in those countries?

Mr. CRANE. I would presume that anyone who is concerned about quality health care is representing workers and nonworkers and government employees.

Mr. MEANY. When you talk about Britain, I am wondering if the Labor Party sent someone over here to tell you what they thought about their plan?

Mr. CRANE. I know what the Labor Party would say, because I know what Barbara Castle's position is, but her position is irreconciliable with the facts. One can be wedded to a doctrinaire position, as Barbara Castle is, and inflict great hardship on working people simply because she has some grand Utopian dream which fails in realization and practice. Here, I think, we have a mutual concern and interest in guaranteeing quality health care, and simultaneously not squandering dollars.

Mr. MEANY. We are not advocating the British system. We make that quite clear.

Mr. CRANE. I can understand that, but once you have government monopoly control of health care, don't you run the danger of the efficiencies of our postal system?

Mr. MEANY. I don't think this bill would amount to a Government monopoly of health care.

Mr. CRANE. You won't foreclose the alternatives, I understand, in the private sector, which Barbara Castle would do, and is attempting to do in Great Britain. Still, the problem remains of diminished dollars available if you are going to co-op the $100 billion we are spending on health care and let the Government spend that $100 billion. So, it makes it increasingly difficult for alternatives to survive.

My time is limited, but I want to get to another point in your testimony. That is that the assertion, and you are certainly not alone in making it, that health care is a matter of right. You use the parallel to education, and I wonder how far you are willing to carry that concept?

Is food a matter of right?

Mr. MEANY. Somewhat.

Mr. CRANE. Food.

Mr. MEANY. It should be.

Mr. CRANE. Housing?

Mr. MEANY. Yes.

Mr. CRANE. Entertainment?

Mr. MEANY. No.

Mr. CRANE. Why would you divorce entertainment?

Mr. MEANY. I think there is a difference between entertainment and transportation and food and medical care.

Mr. CRANE. Are you suggesting that we ought to have comprehensive Government programs here that would guarantee without a means qualification that anyone of us could go into the local grocery store, get whatever food someone——

Mr. MEANY. No; I am not advocating anything like that. I am advocating a type of Government that provides jobs and provides incentives for jobs so that the people would have the money to go into the grocery store.

Mr. CRANE. I am in a 100-percent agreement with you on the desirability of creating jobs, Mr. Meany.

Mr. MEANY. In other words, in my long experience, there is no greater defender of the private enterprise system than the American trade union movement.

Mr. CRANE. With some minor reservations, I would agree with you on that, and I commend you for being a staunch defender of our economic system, basically.

But I do feel it is hard to extend the concept that someone has a right to the services of the people within your unions as you employ with respect to health care. The language troubles me just a little bit, because I would rather approach that problem the way you suggest with respect to food.

Unfortunately, my time has expired. Again, it is a pleasure to have you before us.

Mr. MEANY. I would like to talk to you about this whole business of rights and socialism. Going back in history, you will find out there are a lot of inconsistencies from the conservative side; you know.

The school lunch program is a socialist program. Giving to the Union Pacific to push the railroad to the west coast, that is not socialism. Giving the airlines a subsidy to develop so we would have an air industry, that is not socialism, but giving money to the poor is socialism. I would like to talk to you. [Laughter.]

Mr. CRANE. I did not vote to bail out Lockheed. I would like to explore that point with you, too.

Mr. ROSTENKOWSKI. Mrs. Keys will inquire.

Mrs. KEY. Mr. Meany, it is a pleasure. This is the first time I have had the opportunity of hearing you testify before a committee on national health, although I know you have been one of the advocates and leaders in the drive to bring some kind of equity in access to health care in this country.

I would like to ask one question, as some have expressed the concern about the costs. I wonder if we aren't overlooking a fact that in a way, we have really begun to prepare the way for a national health bureau program in health planning, in health manpower, by PSRO, and by utilization review.

Aren't these all chinks that are put into place, even though they have been reduced some now due to the priorities of the present administration. They are put in place to lead us to a comprehensive national health program.

Mr. MEANY. I agree.

Mrs. KEYS. Do you think they will help us a great deal as we implement a more comprehensive program?

Mr. MEANY. Yes.

Mrs. KEYS. Do you see universality as something that will help in terms of the administration, help lower the administrative costs?

Mr. MEANY. That is part of our theory. That is the reason we are supporting this particular bill.

Mrs. KEYS. And a comprehensive program which would eliminate the separate medicare-medicaid, et cetera, would not that also lower administrative costs?

Also, the fact that it is a totally prepaid program which does not require a lot of proof of eligibility of different copayments at the time, but is all paid in advance. Wouldn't this help the administrative costs?

Mr. MEANY. We feel that way, and we feel that a lot of the waste, the duplication, can be eliminated by a comprehensive, overall program. This is part of the theory.

As far as costs are concerned, if the figures are all right, and I am sure they are—they come from HEW—health expenditures have increased 50 percent since I last testified before this committe, and the Government's expenditures have increased 84 percent since then.

So, the cost certainly is going up under the present system and we feel that we have a comprehensive system such as outlined in this health security bill, that would eliminate a lot of the waste, a lot of the duplication, and bring the costs down.

Mrs. KEYS. Thank you very much. I certainly agree that having access to health care at costs that you can afford, or you can prepay, is an essential right of every citizen in this country in 1975, and I am interested in seeing us pass that kind of a program.

Thank you very much.

Mr. MEANY. Thank you.

Mr. ROSTENKOWSKI. Mr. Meany, I want to thank you very much for joining us this morning. You have been most informative, and you are always welcome to this committee, but I hope this is the last time on national health insurance.

Mr. MEANY. Thank you very much.

Mr. ROSTENKOWSKI. Mr. Jeffery Cohelan? Mr. Gibson Kingren.

Mr. Cohelan, you may begin your testimony.

STATEMENTS OF JEFFERY COHELAN, EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION OF AMERICA; ACCOMPANIED BY GIBSON KINGREN, VICE PRESIDENT, KAISER FOUNDATION HEALTH PLAN, AND JAMES LANE, REGIONAL COUNSEL, KAISER FOUNDATION HEALTH PLAN

Mr. COHELAN. Thank you, Mr. Chairman.

My name is Jeffery Cohelan, and I am executive director of the Group Health Association of America. GHAA is an organization which represents the major prepaid group practice plans in the country, the basis of the Health Maintenance Organization concept. Our interest in national health insurance is devoted primarily to how national health insurance will impact on HMO's. My testimony, this morning, therefore, will deal mainly with the role Health Maintenance Organizations should play in any proposal that is ultimately adopted by Congress.

Over the past few decades, prepaid group practice has been recognized as a workable and desirable alternative mode of health care delivery. I should stress that none of us involved in this system have ever maintained prepaid group practice, or HMO's, as the only method by which health care should be made available to consumers. Our system of care should be considered as an alternative to the traditional fee-for-service concept within the framework of the entire health services mechanism.

By the same token, Mr. Chairman, we do not consider ourselves to be an experiment. In those areas where HMO's have been relatively free to organize and operate, their success has more than justified the recent recognition they have been given. One cannot consider the Kaiser program with 2.8 million members in six States, or the Group Health Cooperative of Puget Sound, with over 180,000 members, or the Health Insurance Plan of Greater New York, with nearly three-quarters of a million members, as a mere experiment. Indeed, these plans and their continued growth has demonstrated the advantages of combining the financing and delivery mechanisms of care into a single entity. The resultant economic efficiencies and quality care in such organizations serve the consumer well. The prepayment feature offers the consumer a broad range of health care services paid for in advance at a time when they can best be afforded.

It was no wonder, then, we were heartened by the enactment of the Health Maintenance Organization Act of 1973. This commitment of support for independent, financially viable HMO's came as good news to us and, more importantly, generated an interest in HMO's by all sectors of the American economy concerned with the spiralling costs of health care. As a result, American business, insurance companies, quarters of a million members, as a mere experiment. Indeed, these consumer groups, labor and providers have in varying degrees evinced an interest in the development of Health Maintenance Organizations.

Unfortunately, as with any new Federal program, there are a number of problems with the HMO program which have retarded their development, including restrictive provisions in the act, lack of sufficient funding, and difficulty in administration of the program. We are confident that the amendatory legislation now before the Congress will, if adopted, solve most of these problems and HMO's will then be able to experience their anticipated growth.

Mr. Chairman, we believe that Health Maintenance Organizations should play a key role in any national health insurance scheme adopted by the Congress. We believe the Congress, and this committee in particular, should ensure the HMO's are included in any national legislation in a manner that will allow their growth under any national health insurance plan adopted. We do not ask for special treatment or special exemption. We do ask that those traditional impediments to our growth and development be removed. We ask that the reimbursement of HMO's be related to community cost of care and not to the costs of the HMO or the particular provider alone.

If the payments for the same health care benefits are equitably distributed to the HMO and other systems, then the HMO's can continue to utilize their cost savings for the provision of additional benefits as they do now. We are concerned and disappointed that the Congress did not fully adopt this principle when it enacted the HMO amendments to the Medicare law 3 years ago. HMO amendments allow HMO's to retain only part of their savings, while being asked to assume all the risks of the covered services. Thus, HMO's will be denied much of the savings which accrue from their lower hospitalization rates and their emphasis on preventive care. We would have preferred, and still prefer, a prospectively determined payment based on the costs of providing similar care in the community. Therefore we urge Congress not to repeat this unfair payment formula for HMO's under a national health plan. HMO's should be reimbursed based on the cost of the benefits tot he community at large whether under a federally administered or federally mandated national health insurance program. I might add that we believe that both medicare and medicaid should be amended to contain the same payment principle. Accordingly, such equitable treatment to HMO's will have a salutary effect on the delivery of health services in the United States.

With the development of the national HMO strategy, there has been a concurrent recognition of the relative value of HMO's in the health care field. Studies of the Federal Employees Health Benefit Plans (FEP) have shown that HMO-type organizations experience one-half to one-third less hospital days than the indemnity or service benefit plans while providing broader range of benefits. Just a couple of weeks ago, the new rates for the Federal Employees Health Benefits were announced. The HMO increases on the whole are somewhat less than the other plans. Perhaps the most important effect of these rate changes is that HMO's are becoming more competitive price wise. As a result of these changes, we expect a higher participation by Federal employees in this, the largest health insurance program in the Nation, as the premium approach those in the private sector.

The merits of HMO's have been recognized in other quarters. The Council for Economic Development, representing leaders of American business, recommended in its lengthy report entitled "Building a National Health Care System" that to achieve a national health care system which stresses prevention as well as cure (1) financing must be based on prepayment for an essential set of benefits, and (2) that to the maximum feasible extent providers of care must be paid in accordance with fees and charges fixed in advance by agreement with providers and related to a budget that reflects efficient organization and procedure. The report concluded by saying that the application of the concept of the Health Maintenance Organization represents an admirable response to such a payment system.

Other sources including Consumer Reports, in an October 1974 study, note that studies had consistently found less hospital use and fewer surgical procedures among HMO patients. In the opinion of the noted consumer expert, Sidney Margolis, HMO's use of auxiliary personnel, having their own labs and physicians and the HMO's emphasis on preventive medicine all keep the costs lower while providing quality of care. And, in a recent study entitled "HMO Performance: The Recent Evidence," Milton Roemer and Williams Shonick stated that the evidence so far suggests that the potential of HMO's, based on the PGP model, to provide good health service at relatively lower costs than the traditional open-market private medicine model is substantial.

HMO's also do not appear to be suffering from the current crisis in malpractice insurance. In an article appearing in the most recent issue of the Northwestern University Law Review entitled, "The Malpractice Experience of Health Maintenance Organizations," Professor William J. Curran of the Harvard Law School, a leading health law expert, found that the malpractice crisis was not greatly evident in those HMO's surveyed. He concluded that the "large and well operated HMO's which were the subject of this study were found generally to deal quite well with the operational aspects of medical malpractice."

In summary, Mr. Chairman, the evidence is conclusive that HMO's provide consistent quality care and have been effective in containing escalating health care costs. HMO's are a viable alternative to the traditional fee-for-service system and have proven themselves in the health marketplace when given the opportunity. We urge that any national health program drafted by this committee accord HMO's an equitable place with other modes of health care delivery.

I would be happy to answer any questions you may have at this time and will be willing to comment at length on any specific proposal at the appropriate time.

Mr. Rostenkowski. Mr. Kingren, you may proceed with your testimony.

STATEMENT OF GIBSON KINGREN

Mr. Kingren. Thank you. I am Gibson Kingren, vice president and Washington representative of Kaiser Foundation Health Plan, I am accompanied by Mr. James Lane, legal counsel for Kaiser Foundation Health Plan.

The Kaiser-Permanente medical care program is comprised of Kaiser Foundation Health Plan, a nonprofit corporation, Kaiser Foundation Hospital, a charitable and nonprofit corporation, and six independent Permanente Medical Groups. The program is an economically self-sustaining health care system that provides prepaid health care services to more than 2.8 million members in California, Oregon, Washington, Hawaii, Ohio, and Colorado. It is a systematically planned and organized approach to the provision of health care that arranges direct health care services for its members in 24 acute general hospitals and more than 60 outpatient facilities. Professional services are provided by more than 2,800 physicians associated with the independent Permanente Medical Groups.

The Kaiser-Permanente program is the largest group practice prepayment program in the United States. It has succeeded and grown in the face of health competition from commercial health insurance. Blue Cross, Blue Shield, and self-insured programs, and despite the historical opposition of some segments of organized medicine. The program has pioneered many features, such as comprehensive prepaid services—including prevention and early detection of disease—quality care based on peer review and effective cost control—particularly with regard to expensive hospital services—that Congress sought to encourage and expand by enacting the Health Maintenance Organization Act of 1973. Many of the program's attributes also are mentioned as objectives for national health insurance programs.

IMPORTANCE OF GROUP PRACTICE PREPAYMENT PROGRAM

The Congress gave encouragement to the development and expansion of group practice prepayment programs when it enacted the HMO Act and the HMO amendments to medicare. This occurred because such organized health care systems have demonstrated their ability to provide a comprehensive range of prepaid health services to their members at a reasonable cost. Prepaid group practices are at the forefront of innovation in health care delivery and have led in providing preventive health services and using health care resources efficiently. Furthermore, the success of group practice prepayment programs has resulted in innovative responses from traditional health care providers, such as the development of the Foundations for Medical Care and the expansion of the prepaid benefits offered by competing health benefits carriers.

Over 5 million Americans are members of group practice prepayment programs and many other Americans will join such programs as they become available throughout the country.

The goals for national health insurance legislations should include many of the outstanding features of group practice prepayment programs such as preventive health care, reduction of unnecessary surgery, the efficient use of physicians and paramedical personnel, and reduction of hospitalization through practical controls on utilization. Finally, an essential goal of NHI legislation should be the nurturing of financing mechanisms that will encourage efficient use of health care resources.

There are the strengths of group practice prepayment programs. They should be permitted to participate in any national health insurance program on an equal basis and with sufficient freedom to encourage them to continue to innovate in the delivery of health care services. It is ironic that some NHI proposals would threaten the continuation of such programs even though they provide for participation by health maintenance organizations.

HOW PREPAID GROUP PRACTICE PROGRAMS ATTRACT MEMBERS

Most persons become group practice prepayment plan members through a health benefits plan offered by their employer or a health and welfare trust fund which provides them with a choice between a group practice prepayment plan and one or more service benefit—Blue Cross or Blue Shield—or indemnity benefit plans—insurance carriers.

An individual selects coverage under a group practice prepayment plan because group practice prepayment programs provide greater value for the health care dollar. Independent studies have shown that health plan members get 20 or 30 percent more in benefits for each dollar of dues than they can get under insurance policies or the Blue programs.

The subscriber determines this by comparing the benefits and cost of the available alternatives. If the employer pays 100 percent of the premium, the benefits of the group practice prepayment program must be greater than that of the alternate carrier to be attractive. If the employer pays part of the premium, the employee's share must be less than he would pay to the alternate carrier for similar benefits or only slightly more for greater benefits in order to be attractive. Only the more sophisticated consumers analyze total out-of-pocket health care costs in making their choice.

If the benefits provided by the group practice prepayment plan and the alternate carrier are the same and the cost to the member is the same, a major attraction to new enrollees in such programs is lost. Therefore, any proposal which provides a specific set of benefits, costs persons the same regardless of how they receive their health care and reimburses providers on the basis of their costs, seriously erodes the attractiveness of group practice prepayment programs. This is precisely what a number of NHI proposals do.

IMPORTANCE OF EQUAL PAYMENT

A basic principle of an NHI program should be that the same average expenditure per person will be made for health care services, regardless of how any person chooses to obtain such services.

If this principle is adhered to, group practice prepayment programs and other systems which operate efficiently will be able to offer prospective members a benefit plan of greater value than can be obtained from less efficient providers. Depending upon how the NHI program is designed, this could take the form of additional benefits such as mental health and dental services; elimination or drastic reduction of deductibles, coinsurance and copayments; or lower premiums or periodic charges.

PROPOSED SOLUTIONS

This basic principle is violated by any program which pays for services on the basis of the actual costs of each provider, since there will be no incentive to constrain costs. An NHI program should not reimburse providers on the basis of their costs since efficient providers will be penalized when they reduce costs and inefficient providers will be rewarded when their costs increase.

If an NHI proposal requires an employer to offer a health benefits program to its employees, the employer should be required to offer the option of membership in a group practice prepayment program if one is available in the area. In addition, the employer should be required to make the same dollar contribution to the group practice prepayment program as to the alternate carrier.

If the proposal utilizes tax credits, the credit should not be based upon the price of the approved health benefits plan selected, but should be the same regardless of which plan is selected. If the proposal requires the Federal Government to pay part of the premium costs of an approved benefits plan, the amount paid by the Government should be the same regardless of which plan is selected.

If the proposal provides that the Federal Government will be the insurer, as in the medicare program, group practice prepayment programs should be paid for the benefits they cover on a per capita basis, rather than a fee-for-service basis. The amount of the periodic payment should be the amount determined prospectively that the same covered services provided on a fee-for-service basis will pay in the same geographical area.

If the proposal provides that the Federal Government will allocate available health care service funds, the allocation should be on a per person basis and group practice prepayment programs should receive the same payment per covered person as other providers.

EQUITABLE TREATMENT UNDER OTHER LAWS

The proposal developed by the committee may continue the medicare and medicaid programs or may federalize medicaid. If so, these programs should be modified so that the provisions relative to reimbursement of group practice prepayment programs are consistent with the basic principle we have recommended. The HMO provisions of medicare are not consistent with that principle and medicaid provisions vary from State to State.

As we indicated in our written presentation to the committee on April 11, 1975, the HMO Act of 1973 has placed certain requirements upon HMO's which are not placed upon other carriers. We emphasize again that in the interest of equity, those requirements should be eliminated or imposed upon all carriers.

CONCLUSION

Group practice prepayment programs are a unique American innovation in the field of health care delivery. These programs have grown and prospered with little or no Government assistance and despite significant competition and substantial opposition from traditional elements of the health care industry. Five years ago, group practice prepayment programs were rechristened health maintenance organizations, and held out as part of the solution to the health care problems of this country.

There is an emerging consensus that HMO's are desirable and should be encouraged by the Federal Government. It is therefore perplexing to find that most NHI proposals demonstrate little appreciation of the complexities of group practice prepayment programs and do not contain the specific provisions necessary to assure equitable treatment for such programs.

This issue is of vital importance to the Kaiser-Permanente medical care program. We would like to work with the committee and its staff in developing appropriate technical language to attain the objective of permitting organized health care systems, specifically group practice prepayment programs, to participate in a national health insurance program in an effective and viable manner.

Thank you, Mr. Chairman and members of the committee. We would be pleased to answer questions.

Mr. ROSTENKOWSKI. Thank you, Mr. Kingren and Mr. Cohelan.

Are there any questions of the witness?

Mr. Duncan?

Mr. DUNCAN. I would like to welcome our able friend, Mr. Cohelan, back to the committee. He has testified here before.

I have just one question. Do you believe HMO's and similar types of prepaid group practice plans should be universal and available, and are there certain areas where, for various reasons, such plans might not be feasible, such as inability to attract a sufficient number of physicians or the inability to market the plan?

Mr. COHELAN. I think there are areas of the country where it would be difficult to organize a prepaid group practice program, although it is true that there are other systems—foundations for medical care, for example—where the mechanism could be implemented and is being implemented in some parts of the country. But there is no gainsaying the fact that you have to have a defined population in order to develop a viable HMO.

Mr. DUNCAN. Does it take several years for a HMO to operate at a break-even position, even under optimistic conditions?

Mr. COHELAN. The actual experience has been roughly that the startup costs in an HMO will vary with whether or not they start with facilities or have to build facilities. The figures seem to indicate, Mr. Duncan, that it is anywhere from a quarter of a million dollars to several million dollars, and on the average, the experience seems to show from the records that we have that it takes about 5 years, given even a healthy developing program, to reach the break-even point. Some of the programs, even some of our more sophisticated programs, will frequently take longer than that.

It is not easy to organize a prepaid group practice plan. It costs a lot of money.

Mr. DUNCAN. But you do think you can get them on a break-even basis?

Mr. COHELAN. Oh, I have no doubt about it, and we have ample examples to support that statement. But they need capital support. Where there has been adequate capital support, we have shown in most instances that they can be successful.

Mr. DUNCAN. Since most of the HMO's do not break even for the first few years, do you think that would create particular problems in trying to develop HMO's in connection with the NHI proposals?

Mr. COHELAN. Historically, as you know, there have been barriers to the development of prepaid group practice programs in many of the States in the country, and there have been efforts in Federal legislation to try to offset that, although not entirely successfully. There are continuing problems because of the diversity of our States.

But with respect to the national health insurance proposals, the thrust of our testimony here this morning is to urge the committee to give very careful attention to the payment mechanism so that we concentrate on incentives. In your own considerations, it is very clear that if we are—if consideration is given to the proper payment mechanism, the prepaid group practice health maintenance organization concept will be able to compete very effectively in that market, and improve the efficiency of health care delivery.

Mr. Duncan. How many HMO's are operating today in this country?

Mr. Cohelan. I would say that at the present time, according to the best figures we have, there are about 174.

Mr. Duncan. And of that number, how many would you say are breaking even?

Mr. Cohelan. On the break-even point, of the 174—I think of the 173, there are probably 40 major programs that are operating in a viable capacity. Most of the rest of them are developing programs. Most of this development has taken place since the passage of the Health Maintenance Organization Act of 1973.

I would remind the gentleman that this afternoon you will be considering amendments which will help us stimulate even further the development of viable prepaid group practice programs.

Mr. Duncan. Thank you very much, and thank you also, Mr. Kingren.

Mr. Kingren. We were talking principally about group practice prepayment plans, but I think implicit in your question is "How can one provide an alternate delivery system to people who live in isolated rural areas?"

I do not think that the group practice prepayment method of organizing and delivering health services lends itself to that kind of a situation, but I do think the important consideration is that in any national health insurance law that is passed, there should be encouragement to develop new and more efficient ways of delivering health care and paying for it.

We do not believe that we have the final answer by any means. Only by having an opportunity to develop new systems can progress really be made. We believe sound public policy demands that this be a part of any NHI program.

Mr. Duncan. My time is up. Thank you for your contribution.

Mr. Rostenkowski. Mr. Corman?

Mr. Corman. Thank you, Mr. Chairman.

I would like to observe that when we talk about a national health security program preserving that which is best in American medicine, preserving and expanding health maintenance organizations is what I have talked about. I believe if there is a comprehensive and universal national health insurance system, and if beneficiaries have the option of getting their care through an HMO or through fee-for-service, they will opt for good HMO's. There will be strong competition among and between HMO's and private fee-for-service.

We talk about building blocks in this health system as we move forward, and the development, particularly of Kaiser, which I am most familiar with, over the years has proven that this kind of delivery system works extremely well. I am pleased that my colleague is here to remind us that there has been great progress, and there can be more if we give equal competing roles to the development of HMO's.

Mr. Rostenkowski. Mr. Cotter?

Mr. Cotter. Thank you, Mr. Chairman. It is a pleasure to see Jeff Cohelan here.

I have a question for Mr. Kingren. You people pioneered preventive care medicine. Am I correct? You have been in the forefront in that area.

Mr. Kingren. Yes.

Mr. Cotter. Could you describe the kind of preventive medicine provided in your program?

Mr. Kingren. First of all, we feel people should be encouraged to bring minor ailments to the attention of the physician early, so that they can hopefully be prevented from becoming serious.

Mr. Cotter. Is this including checkups?

Mr. Kingren. I was mentioning care for early symptoms—for example pains in the stomach. Health plan members are encouraged to see the doctor soon so he can make the decision whether or not there is serious illness and prescribe a course of treatment.

Frequently an illness when treated early can be prevented from becoming more serious, and, hence, more costly for us to take care of and with less inconvenience and less pain for the patient.

However, we found that physicians frequently were spending a great deal of time in repetitive procedures in providing physical examinations to well people. This stimulated the Kaiser-Permanente program to develop a multiphasic testing program which is largely automated. This automated physical examination is available to all members and is operated by specially trained paramedics under the supervision of a physician.

When the member has taken the tests the results are evaluated before he leaves the facility and if there is any abnormality that requires immediate attention, he is taken to a physician.

For those members with abnormalities which are noted and do not require immediate attention, an appointment is made for them to see a physician at another time.

For a long time, we questioned whether these physical examinations really help people to stay well, and reduce medical costs. However, now we think there is a some evidence showing that it costs less money to provide the medical care, and there is less lost time from work for those people who routinely take these physical examinations.

We cannot require our members to take routine physical examinations, but we can encourage them, and we do.

We also have preventive care in another direction. Pediatric care has always been provided. That is well-baby service during the first year of the life of the child. The child is examined each month, as just part of the regular program. We expect them to bring the child in, and they do.

But to say that we can keep people well through prevention is really not true.

Mr. Cotter. Nor do you have any cost savings studies as a result of that?

Mr. KINGREN. No, we really do not have.

Mr. COTTER. You feel it does ultimately result in a saving, but you do not have studies to back it up at this point. Is that correct?

Mr. KINGREN. Except for the data we have been accumulating lately, which seems to show a trend in the direction of a saving. I would be glad to furnish some of this information to the committee if you would like.

Mr. COTTER. Thank you, very much, sir. I would like to have this data when available.

[Information follows:]

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Evaluation of a Periodic Multiphasic Health Checkup

(From the Department of Medical Methods Research, The Permanente Medical Group and The Kaiser Foundation Research Institute, Oakland, California)

L. G. Dales, G. D. Friedman, M. F. Collen

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A controlled trial aimed at testing the efficacy of periodic Multiphasic Health Checkups in preventing or postponing morbidity, disability, and death has been in progress since 1964. After seven years of follow-up the most striking findings are: 1) a reduction in self-reported disability among men aged 45—54 at entry who were urged to take the periodic checkups; and 2) in the urged group as a whole, a reduction in mortality from a collection of causes deemed beforehand to be potentially postponable through use of periodic checkups. There are no strong indications that chance fluctuation, selective loss to follow-up, selective under-reporting, or initial health status discrepancies can explain the mortality difference.

Key-Words: Periodic Health Checkups, Multiphasic Screening, Automated Multiphasic Health Testing, Preventive Medicine Evaluation

AUSWERTUNG EINER PERIODISCHEN MULTIPHASISCHEN VORSORGE-UNTERSUCHUNG

Seit 1964 wird in einer kontrollierten Versuchsreihe die Effektivität von Vorsorge-Untersuchungen bezüglich der Verzögerung von Morbidität, Invalidität und Mortalität untersucht. Am Ende einer siebenjährigen Laufzeit der Studie zeigen sich folgende wesentliche Resultate: (1) bei Männern im Alter von 45 bis 54 Jahren, die zu periodischen Untersuchungen angehalten worden waren, eine Verringerung des selbstberichteten Arbeitsausfalls wegen Krankheit; (2) allgemein eine Verringerung der Mortalität aus Ursachen, die von vornherein als durch Vorsorge-Untersuchungen reduzierbar gekennzeichnet worden waren. Es ist unwahrscheinlich, daß es sich bei der Mortalitätsverringerung um Zufall, selektiven Beobachtungs- oder Berichtsverlust oder um Unterschiede in der Anfangsmorbidität handelt.

Schlüssel-Wörter: Periodische Vorsorge-Untersuchungen, Massenuntersuchung (multiphasisch, automatisiert), Bewertung präventiv-medizinischer Maßnahmen

Introduction

The value of periodic general health examinations, as well as of screening for specific diseases, has been debated for years. The controversy has centered around such difficult issues as the natural history of »precursor« or »early« conditions, apparent versus real increases in survival times after diagnosis, and the effectiveness and availability of therapy, particularly where treatment necessitates sustained effort and cooperation by both therapist and patient [8]. It is generally felt that adequate evaluation of periodic health examinations requires a controlled trial, where comparable examined and non-examined populations are identified and followed in identical fashion for morbidity, disability, and mortality.

The majority of evaluation studies published to date compare the health experience of an examined group, often composed of self-selected volunteers, with that of a non-examined group of the general population or of other control groups whose basic comparability to the examined group has been difficult to establish [5, 6, 7, 10]. The number of randomized controlled trials of periodic general health checkups is small, and for most of them the critical information on outcome is not yet available [11, 12, 13]. The *Kaiser-Permanente Multiphasic Checkup Evaluation Study*, a controlled trial which has been under way since 1964, is sufficiently far along for some significant results to have been reported [1, 3, 4, 9]. In the present paper the methodology of the Kaiser-Permanente study is outlined and the results to date are summarized.

Materials and Methods

The Kaiser-Permanente Medical Care Program's Multiphasic Health Checkup (MHC) is comprised of

1) a visit to an automated multitest laboratory for completion of medical questionnaires and a battery of clinical and laboratory tests [2],
2) recommended visits to the gynecology clinic for all women and to the sigmoidoscopy clinic for all persons over 40 years of age, and
3) a follow-up visit with a physician for clinical examination and review of all test results.

In 1964, a group of over 10,000 men and women ages 35—54 belonging to the Northern California Kaiser Foundation Health Plan were allocated on the basis of the terminal digits in their Health Plan identification number into two groups of roughly equal size. Members of the first group, termed the »study« group, have been urged to take multiphasic health checkups annually. The second group, the primary control group, has received no such urging; but its members, since they also belong to the Kaiser Foundation Health Plan, have had access to all other aspects of medical care equivalent to that of the study group subjects. The demographic characteristics of the two groups were quite similar. A large pool of similar subjects has also been available for selection of secondary control groups to be used in special comparative studies.

Neither the subjects nor their physicians have been made aware of the fact that they are in an evaluation study. The health experience of the study group and primary control group subjects has been followed in identical fashion, utilizing five categories of information:

1) *Outpatient Clinic Experience* — Representative subsamples of subjects, comprising approximately 40% of the study and control groups, were selected for manual review of outpatient medical charts covering the years 1962—1969. Trained readers, blind to the study or control group membership status of the patients, abstracted from the medical charts outpatient services utilization and diagnostic data. By 1970 it was possible to substitute for this manual operation an automated review of computer-stored outpatient data for subjects living in and around the city of San Francisco, who represented approximately half of the study and control group subjects.

2) *Multiphasic Health Checkup (MHC) Data* — In order to obtain study—control group comparisons on similarly measured physiologic characteristics as well as on a variety of other information, two secondary control groups were selected on the basis of Health Plan identification number digits from the large pool of potential control subjects and invited in for MHC's. Because exposure to multiphasic health testing — the modality being evaluated in the study — »contaminates« control subjects, the primary control group has not been used for this purpose. The MHC data obtained on the two groups of secondary control subjects, who were called in for checkups in 1966—67 and 1970—71, respectively, have been compared with MHC data secured on study group subjects examined in the same time periods.

3) *Health and Disability Status Surveys* — Periodically, study and primary control group subjects remaining in the Kaiser Health Plan have been surveyed by mailed questionnaire. These surveys contain questions on disability (activity limitations resulting from any medical condition), labor force status, recent illness with attendant time loss from work, utilization of medical care services, including hospitalization, and the presence of chronic conditions. The study group was first surveyed in 1964, together with a specially chosen control group which has not been surveyed since. The primary control group was first surveyed in 1966. Thereafter, the study and primary control groups have been surveyed together biennially (in 1967, 1969, 1971, and 1973).

4) *Hospitalizations* — Data on hospitalizations in Kaiser Foundation Hospitals have been obtained for all study and control group members remaining in the Health Plan. Computer-stored information on hospital utilization has been analyzed for the years 1963—1971. Diagnostic information has been manually retrieved from hospital discharge forms for the years 1963—1970, using trained readers blind to the study or control group membership status of the patients.

5) *Mortality* — Lists containing names and birthdates of study and control group subjects no longer in the Kaiser Health Plan have been submitted periodically to the California State Department of Public Health, Bureau of Vital Statistics. No other identifying information is supplied to the State since our records tend to be more complete for study group subjects, who are contacted annually to be urged to take the MHC's. The State has returned death certificate copies for those Californians who have died during the years 1964—1971 and who match the individuals on the submitted lists by name and birth date. Then, death certificate copies received from the State have been checked against Kaiser-Permanente clinical records to confirm identification of the decedents as study and control group members. Death certificates accepted for analyses have been coded for cause of death (by trained persons unaware of whether they were dealing with study or control group members), using the *International Classification of Diseases, Adapted* (ICD/A), Eighth Revision.

Results

1) *Attrition of the Population* — Due to withdrawals from the Kaiser Health Plan and deaths, the study and control groups have been diminishing in size at an average rate of approximately 3% per year. By mid-1971, seven years after initiation of the project, 78% of study group subjects and a little over 76% of control group subjects remained in the Health Plan. Subjects leaving the Health Plan have been lost to follow-up for analyses of outpatient clinic events, multiphasic checkup variables, health status surveys, and hospitalizations. Where event rates through time have been based on the entire study and control groups or subsamples thereof, the numbers of subjects remaining in the Health Plan at the midpoints of the relevant time intervals have been used for denominators. Subjects no longer in the Health Plan are thought

to remain largely within the mortality surveillance system, since few of these persons are believed to have left the State of California.

2) *Exposure to Multiphasic Health Checkups (MHC's)* — The result of the urging efforts (subjects were contacted mainly by telephone in the evenings) was that, after the project effort was well under way, in each year over 60% of the eligible study group subjects have taken a MHC. Control group subjects, being Kaiser Health Plan members, could not be refused MHC's, and a little over 20% of them have taken a MHC each year on their own initiative. By mid-1971, seven years after initiation of the urging effort, the average cumulated number of MHC's per subject was 3.5 in the study group and 1.3 in the control group.

3) *Outpatient Clinic Experience* — Distributions of annual numbers of physician visits and outpatient laboratory tests used per subject have been computed and compared for the study and control group subsamples described in the prior Materials and Methods section. Physician visits and laboratory tests that form part of the MHC have been excluded. Analysis of these data through 1970 has been completed and indicates no significant study-control group differences in the utilization of these outpatient services. That is, no overwhelming demand for additional outpatient services seems to have been generated by the increased study group exposure to MHC's, nor has there been a notable reduction in utilization.

Distributions of numbers of diagnoses appearing in outpatient clinical records have also been analyzed. Some of this information is summarized in Table 1, where mean annual numbers of newly-recorded diagnoses (of all kinds) per subject for the years 1962—1970 are shown for the study and control group subsamples. Duplications have been eliminated; that is, for any one individual a diagnosis has been counted only once over the 1962—1969 time period. Thus, for each year the frequency of new diagnoses appearing in the outpatient records of study and control group subjects can be compared. In the baseline period before the project effort got under way (1962—1964) the study and control group rates were quite similar. In 1965 a sharp divergence appeared, and in every subsequent year significantly more new diagnoses were found in the records of study group subjects. The 1970 data, unlike those for previous years, came from computer-stored records of different subsamples of study and control group subjects, with diagnostic information maintained in a somewhat different manner. Therefore, the 1970 data could not be combined with those for earlier years so that the cumulation of new diagnoses started again in 1970. For this reason the 1970 rates appear higher than those for the preceding years, though the same study-control group relationship in diagnosis rates continues.

The pattern for individual diagnoses followed that for all diagnoses combined. Both in the manually gathered 1965—1969 data and in the computer-stored 1970 data, the detection rates for many diagnoses were significantly higher ($p < .05$) in the study group. Included among these, and of interest in relation to mortality results (cf. later), were hypertension, benign tumors of the colon, and fibrocystic disease of the breast.

Computer-stored information on prescription-dispensing rates for study and control group subjects living in the area serviced by the Kaiser-Permanente San Francisco medical center's pharmacy has been analyzed for the years 1970 and 1971. For all prescriptions combined, the usage rates were slightly higher in the study group, though the differences were not significant. Included in the categories of drugs where the trend was toward higher usage in the study group were anti-hypertension drugs, thiazide diuretics, diabetes medications, tranquilizers, and appetite depressants.

4) *Multiphasic Health Checkup (MHC) Variables* — As mentioned earlier, in 1966—67 and in 1970—71, two special sets of control subjects, not belonging to the primary control group, were called in for MHC's in order that the data obtained could be compared to those of study group subjects having MHC's during the same time period. Comparisons have been made for many physiologic variables, and in general the result has been that no consistent, significant study—control group differences have been seen (with the possible exception of a trend toward lower blood pressure among the older men in the study group). The self-selection involved when persons respond to the invitation for MHC's may be at least partly responsible for the general similarity. For in 1970—71, of the control group subjects who did come in (64% of those who were invited), over 70% had already had at least one MHC in the past, so that these subjects were not ideal controls.

5) *Health and Disability Status Surveys* — The response rates to the mailed health status surveys have been rather consistently around 75% for both study and control groups, with good study-control group comparability in the age-sex distributions of respondents. In Figure 1 are

Table 1: Mean Annual Numbers of Newly-Recorded Diagnoses per Subject, for Study and Control Groups, 1962—1970

	1962	1963	1964	1965	1966	1967	1968	1969	1970+
Number of Subjects									
Study	2068	2068	2047	1962	1885	1820	1768	1733	1770
Control	2057	2057	2045	1949	1867	1807	1766	1714	1884
Diagnoses per Subject									
Study	0.79	0.70	0.58	0.76 *	0.84 ***	0.74 **	0.74 **	0.68 ***	1.51 ***
Control	0.80	0.70	0.58	0.63	0.63	0.59	0.63	0.54	1.28

+ Data for 1970 come from a separate source — see text.

* $p < .05$
** $p < .01$ (Chi square test, based on entire distributions of numbers of diagnoses per subject.)
*** $p < .001$

presented the percentages of survey respondents reporting partial or complete disability. Disability was defined in the survey questionnaire as a state of health resulting in either inability to do one's usual work (complete disability) or the necessity of limiting the amount or kind of work (partial disability). The data are presented separately for four age-sex subgroups of study and control subjects: men and women ages 35—44 and 45—54 at entry to the study in 1964. Study group subjects are represented by the solid line, control group subjects by the interrupted line. The isolated point plotted for 1964 represents the result for the specially chosen secondary control group which was surveyed in that year only. Among the older men (ages 45—54 at entry) there emerged in 1969 a statistically significant ($p < .05$) control group excess in self-reported disability. Specifically, the differences for partial disability alone and for partial and complete disability combined were significant. In 1971 a similar, though slightly less pronounced, difference was seen. While the difference in combined (complete plus partial), disability was no longer significant in 1971, there was still a significant difference ($p < .05$) in the prevalence of partial disability favoring the study group men. In both the 1969 and 1971 surveys the older men in the control group also reported a higher retirement rate and more work time loss and physician utilization for illness. Similar study-control group differences were not seen for the other three age-sex subgroups in any of the survey years.

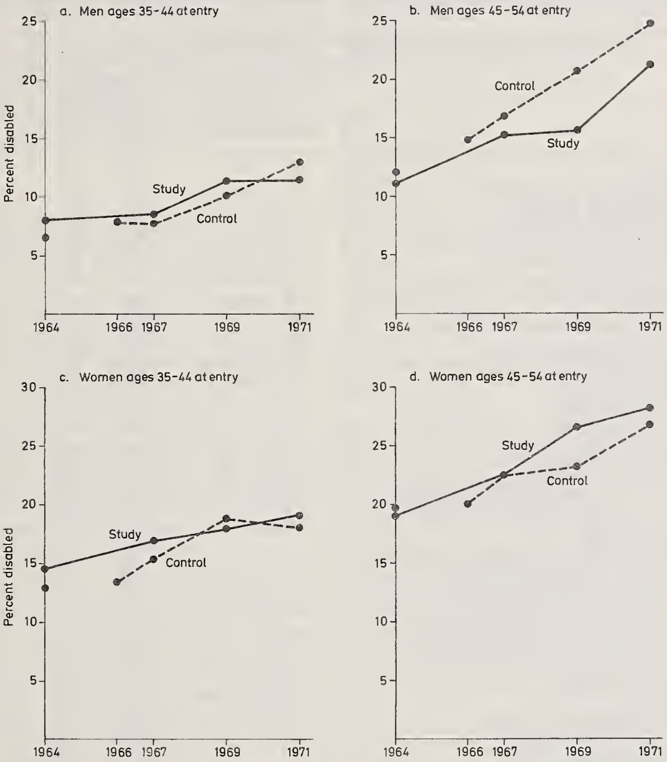

Figure 1: Percent of Health Status Survey Respondents Reporting Partial or Complete Disability, 1964—1971

The health status survey was repeated in 1973, with new questions added to obtain information on the causes of and extent of disability. Analysis of this survey is in progress.

6) *Hospitalizations* — There has been extreme variability in the hospital usage rates (calculated from distributions of numbers of hospital days used per subject per year) within as well as between the study and control groups. While there were no statistically significant differences, among the older men (ages 45—54 at entry)

there were consistently lower utilization rates in the study group in the later years, 1968—1971. The trend among the older women was the opposite, with the lower utilization rates in the control group. When the hospital usage data were subclassified by diagnostic category, no single group of diseases stood out as the major contributor to the trends just described. For example, hospitalizations for malignant neoplasms, mental conditions, hypertensive diseases, respiratory diseases, and genitourinary system disorders all contributed to the higher hospital utilization rates observed for the older men in the control group.

Table 2: Deaths and Death Rates in Study and Control Groups, By Cause, 1965—1971^{+}

Condition	No. of Deaths *Study*	No. of Deaths *Control*	Death Rate (Per 1000 for 7-Yr. Period) *Study*	Death Rate (Per 1000 for 7-Yr. Period) *Control*	Chi Square *Value*
All Causes	183	217	35.6	39.2	0.95
Potentially postponable causes	19	41	3.7	7.4	6.55**
Cancer of colon & rectum	2	10	0.4	1.8	4.77*
Cancer of breast (women only)	4	9	1.4	3.1	1.71
Cancer of cervix & uterus (women only)	0	2	0.0	0.7	0.46
Cancer of prostate (men only)	0	1	0.0	0.4	0.00
Cancer of kidney	0	0	0.0	0.0	0.00
Hypertension & hypertensive cardiovascular disease	3	12	0.6	2.2	4.76*
Hemorrhagic cerebrovascular disease	10	7	2.0	1.3	0.78
Other Causes	164	176	31.9	31.8	0.00
Infectious & parasitic disease	5	1	1.0	0.2	1.74
Cancer of buccal cavity & pharynx	0	1	0.0	0.2	0.00
Cancer of esophagus	2	1	0.4	0.2	0.00
Cancer of stomach	2	4	0.4	0.7	0.10
Cancer of pancreas	2	7	0.4	1.3	1.50
Cancer of small bowel, liver, biliary tree, periton., & unspec. digest.	0	2	0.0	0.4	0.43
Cancer of bronchus & lung	11	12	2.1	2.2	0.00
Cancer of bone, connective tissue, & skin	1	1	0.2	0.2	0.43
Cancer — chorioepithelioma (women only)	1	0	0.4	0.0	0.00
Cancer of ovary & tube (women only)	4	2	1.4	0.7	0.21
Cancer of brain	1	1	0.2	0.2	0.43
Cancer — metastatic (primary site unspecified)	2	6	0.4	1.1	0.91
Cancer — lympho-hematopoietic	8	3	1.6	0.5	2.66
Endocrine, nutritional, & metabolic disease	3	3	0.6	0.5	0.10
Nervous system & sense organs	1	2	0.2	0.4	0.00
Ischemic heart disease (unassociated with hypertensive cardiovascular disease)	51	48	9.9	8.7	0.46
Non-hemorrhagic cerebrovascular disease	0	2	0.0	0.4	0.43
Other circulatory system disease	8	8	1.6	1.4	0.02
Respiratory system	7	11	1.4	2.0	0.61
Cirrhosis	13	18	2.5	3.3	0.48
Other gastrointestinal disease	4	6	0.8	1.1	0.04
Genitourinary system	4	6	0.8	1.1	0.04
Skin and subcutaneous tissue	0	1	0.0	0.2	0.00
Musculoskeletal system	3	3	0.6	0.5	0.10
Accidents, poisoning, & violence	31	27	6.0	4.9	0.66

$^{+}$ Populations as of January 1, 1965: Study, 5141; Control, 5539.

* $p < .05$ } Chi square test
** $p < .025$ } Chi square test

7) *Mortality* — In Table 2 appear the numbers of deaths and death rates in the study and control groups for the seven-year period, 1965—1971. Deaths in 1964, which occurred after the study and control groups were defined but before the project effort of urging study group subjects to take MHC's was well under way, have not been included. At the far right of the table are the chi-square values for the study-control group comparisons (Yates' continuity correction has been applied where appropriate).

The disease and body system categories shown in Table 2 are self-explanatory with one exception: the »potentially postponable« category represents a collection of causes of death selected by a small group of physicians (before the mortality results were known) as being most likely to be reduced in persons taking periodic MHC's. Cancers of the colon, rectum, breast, cervix, uterus, kidney and prostate, hypertension and hypertensive cardiovascular disease, and intracranial hemorrhages comprise this category.

Inspection of the top row of Table 2 reveals that the overall mortality rate was a little higher in the control group, but the difference was not significant. However, for the potentially postponable group of deaths the control group rate was twice that of the study group, a statistically significant difference ($p < .025$). The largest contributions to the difference in potentially postponable death rates came from colon and rectal cancer and hypertension-hypertensive cardiovascular disease. When the data were studied on an annual basis, it was found that the control group death rate from the potentially postponable group of causes was higher than the study group rate in every year, from 1965 through 1971. When the mortality findings were examined for each of the four age-sex subgroups separately, it was found that the largest contributions to the study-control group difference in potentially postponable deaths came from the older men and women (ages 45—54 at entry).

Discussion

The most notable study-control differences in health outcomes through 1971 appear to favor the study group: less survey-reported disability among the older men in the study group, and fewer »potentially postponable« deaths in the study group as a whole. Explanations for these differences other than one of a direct cause-effect relationship between periodic MHC's and subsequent health outcome must be considered.

First, *could these differences represent chance fluctuations?* The study group reduction in partial disability reported by the 1969 and 1971 health status survey respondents, while statistically significant ($p < .05$), was limited to one of the four age-sex subgroups of subjects, the older men. However, this difference in disability prevalence was accompanied by similar differences for a number of other survey-reported health indices and was seen in two successive surveys. The study group reduction in potentially postponable deaths, also statistically significant ($p < .025$), represents the test of a hypothesis concerning a specific collection of causes of death compiled before the mortality results were known.

Second, *might the observed differences result from differentially selective loss to follow-up?* The health status surveys were mailed only to subjects remaining in the Kaiser Health Plan, and, in addition, not all subjects responded. However, a check on the ages and hospitalization history of subjects who did not supply survey data in 1971, either because they had left the Health Plan or because they did not return the mailed questionnaire, revealed no indication that the older men in the study group that were lost to survey follow-up by 1971 were in poorer health than those lost from the control group. The number of subjects lost to mortality follow-up, while unknown, is thought to be small, since only a small proportion of persons leaving the Kaiser Health Plan are believed to leave the state of California. Furthermore, there is no reason to suspect any study-control group difference in the number or kind of persons escaping mortality surveillance. Nevertheless, given the numbers of persons who left the Health Plan by 1971 and the numbers of deaths involved, it is numerically possible that loss to follow-up could explain the difference. For example, if one makes the extreme assumption that all subjects leaving the Health Plan escaped mortality surveillance, about 13 additional deaths due to the potentially postponable conditions could be expected. If eight or more of these occurred in the study group and five or fewer in the control group, the now »complete« study and control group mortality rates would no longer be significantly different. However, it can be seen that this possibility is quite unlikely in that it requires that essentially all of the more than 2,000 study and control group subjects who had left the Health Plan by 1971 also had left the State or otherwise made themselves invisible to State mortality certification.

Third, *might the survey-reported disability difference reflect underreporting of disability by the older men in the study group?* If this were the case, it is not easy to explain why the difference in disability prevalence has been confined to just one of the four age-sex subgroups (the older men) and why the older men in the study group reported the presence of just as many chronic conditions as did their control group counterparts.

Fourth, *could the control group subjects have been, by chance, sicker to start with in 1964?* A review of the available information on the initial health status of the study and control groups reveals the following: the mean ages for the study and control groups in 1964 were essentially identical (45 years, 9 months). The sex distributions of the two groups were quite similar (women comprised 54.1% of the study group and 52.4% of the control group). In 1964 the study group and another control group, also chosen on the basis of Health Plan identification number digits (not the primary control group), were surveyed. Among the older men there was no significant difference in the prevalence of disability (see Figure 1). The older men in the special control group did report significantly more ($p < .05$) recent illness, physician visits for recent illness, and hospitalizations in the preceding year (unpublished data). Among the other three age-sex subgroups, the 1964 survey uncovered no real differences in disability or other health status indices.

Hospital utilization in 1963 and 1964 was slightly higher in the study group overall. Among the age-sex subgroups there was considerable variation. For example, for the older men (ages 45—54 in 1964) hospital usage was higher in the control group, while for the older women the trend was in the opposite direction.

With respect to the initial presence of conditions antecedent to the potentially postponable group of deaths, review of the medical charts of approximately 40% of the study and control group subjects for the years 1962—1964 revealed that the initial prevalence rate of diagnosed hypertension and hypertensive heart disease in the study group was 86% of that for the control group. On the other hand, for the cancers included in the potentially postponable cause of death category, the initial prevalence rate was one-third higher in the study group. A similar analysis comparing initial prevalence rates for the causes of survey-reported disability may become possible when analysis of the 1973 survey (which contains a question on cause of disability) is completed.

To pursue further the possibility of initial lack of comparability, potentially postponable category deaths where the antecedent condition (the responsible cancer or high blood pressure) was known to exist before 1965 can be dropped from the mortality tabulations, reducing the number of potentially postponable deaths to 7 in the study group and 20 in the control group. The resulting mortality rates are still significantly different ($p < .025$). As a further refinement, estimates of the initial prevalence rates of diagnosed hypertension or the relevant cancers in the study and control groups can be used to limit the initial populations at risk (that is, the denominators for the mortality rates) to persons free of these disorders. When this is done, the mortality rates (still based on the 7 study and 20 control group deaths) remain significantly different.

There are two pieces of information about »intermediate« events that may strengthen the case for a causal association between MHC exposure and the observed difference in potentially postponable deaths. First, review of the medical records of 40% subsamples of the study and control groups (described earlier) revealed that during the years 1965—1969, after the project effort was under way, significantly more ($p < .05$) cases of hypertension and benign growths of the colon (mostly polyps) were diagnosed in the study group. Second, as has also been reported in the section on outpatient clinic experience, a trend toward higher study group use of anti-hypertensive medication has been seen, at least for the years 1970 and 1971.

Cost Benefit Analysis

A logical extension to demonstration of any health benefits resulting from periodic health checkups is quantification of such benefits in some manner so that they can be balanced against the costs of the program of checkups. Just how many of the study and control group health outcome differences that have been outlined in this report can be claimed as benefits of the periodic MHC's will probably be a matter of controversy at this stage of the study. Even those who would interpret the results of this project with caution, however, may be curious as to how much economic value can be placed on the differences seen.

The most feasible way to try to answer such a question is to translate into economic terms all of the health-related events followed in study and control group subjects for the first seven years after initiation of the project effort (1965—1971) and to compare the expenses for the two groups. Only for the older men (ages 45—54 at entry), where disability, hospitalization, and mortality trends all are in the same direction (favoring the study group), can any sizable study-control group difference in health expenses be found. Accordingly, the direct (MHC and medical care fee) and indirect (income loss) costs associated with the MHC's, outpatient services, hospitalizations, self-reported disability, and mortality have been computed and compared for the older men in the study and control groups. The tabulations are presented elsewhere [1] and may be very briefly summarized here by reporting that the net savings favored the study group older men every year during the 1965—1971 period and was more than $ 800 per man entering the project in 1964, in favor of the study group, for the entire seven-year period.

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References

[1] Collen, M. F., Dales, L. G., Friedman, G. D., Flagle, C. D., Feldman, R., Siegelaub, A. B.: Multiphasic Checkup Evaluation Study. 4. Preliminary Cost Benefit Analysis. Prev. Med. *2* (1973) 236—246.

[2] Collen, M. F., Davis, L. S.: The Multitest Laboratory in Health Care. J. occup. Med. *11* (1969) 355—360.

[3] Cutler, J. L., Ramcharan, S., Feldman, R., Siegelaub, A. B., Campbell, B. A., Friedman, G. D., Dales, L. G., Collen, M. F.: Multiphasic Checkup Evaluation Study. 1. Methods and Population. Prev. Med. *2* (1973) 197—206.

[4] Dales, L. G., Friedman, G. D., Ramcharan, S., Siegelaub, A. B., Campbell, B. A., Feldman, R., Collen, M. F.: Multiphasic Checkup Evaluation Study. 3. Outpatient Clinic Utilization, Hospitalization, and Mortality Experience After Seven Years. Prev. Med. *2* (1973) 221—235.

[5] Forst, B. E.: An Economic Investigation of Periodic Health Examination Programs. Inst. Naval Studies Res. Contrib. 203 (Nov. 1971). National Technical Information Service.

[6] Grimaldi, J. V.: The Worth of Occupational Health Programs. J. occup. Med. *7* (1965) 365—373.

[7] Kuller, L., Tonascia, S.: Commission on Chronic Illness Follow-Up Study: Comparison of Screened and Nonscreened Individuals. Arch. environm. Hlth *21* (1970) 656—665.

[8] McKeown, T., Kroy, E. E. (Eds): Screening in Medical Care — Reviewing the Evidence. (London: Oxford University Press 1968.)

[9] Ramcharan, S., Cutler, J. L., Feldman, R., Siegelaub, A. B., Campbell, B. A., Friedman, G. D., Dales, L. G., Collen, M. F.: Multiphasic Checkup Evaluation Study. 2. Disability and Chronic Disease After Seven Years of Multiphasic Health Checkups. Prev. Med. *2* (1973) 207—220.

[10] Roberts, N. J., Ipsen, J., Elsom, K. O., Clark, T. W., Yanagawa, H.: Mortality Among Males in Periodic-Health-Examination Programs. New Engl. J. Med. *281* (1969) 20—24.

[11] Shapiro, S.: Evaluation of Two Contrasting Types of Screening Programs. Prev. Med. *2* (1973) 266—277.

[12] Thorner, R. M., Djordvecic, D., Vuckmanovic, C., Pesic, B., Culafic, B., Mark, F.: A Study to Evaluate the Effectiveness of Multiphasic Screening in Yugoslavia. Prev. Med. *2* (1973) 295—301.

[13] Trevelyan, H.: Study to Evaluate the Effects of Multiphasic Screening Within General Practice in Britain: Design and Method. Prev. Med. *2* (1973) 278—294.

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Mr. Rostenkowski. Mrs. Keys will inquire.

Mrs. Keys. Thank you. I have just one question. I missed a little of your testimony, I am sorry to say. But I am sure that when someone enrolls in that Kaiser plan, there is no waiting period of, say, 9 or 10 months for prenatural care?

Mr. Lane. No. That is correct, there is not.

Mrs. Keys. I was sure that was true. I feel it is essential as we do something in a national health program that we concern ourselves with health, and not perpetuate what exists in so many of the private insurance coverages now—a waiting period. We, in fact, are not concerned with the health of that mother and the baby until a certain amount of time has passed. I just think it is great that HMO's do not operate on that procedure.

Thank you.

Mr. Kingren. We have no waiting time for any benefits, Mrs. Keys. Once a person becomes a member, they are eligible for all benefits immediately.

Mrs. Keys. Thank you.

Mr. Rostenkowski. Thank you, gentlemen, for appearing before us. It is always nice to see you here.

Mr. Cohelan. Thank you, Mr. Chairman.

Mr. Rostenkowski. Our next witness is Mr. Charles Womer.

STATEMENT OF CHARLES B. WOMER, CHAIRMAN, COUNCIL OF TEACHING HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY RICHARD KNAPP, DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS, AND STEPHEN SUMMERS, STAFF ASSOCIATE, DEPARTMENT OF TEACHING HOSPITALS

Mr. Rostenkowski. Mr. Womer, would you identify yourself, your organization, and the gentlemen with you?

Mr. Womer. It is a pleasure to be here, Mr. Chairman. I am Charles Womer, chairman of the Council of Teaching Hospitals of the Association of American Medical Colleges, and director of Yale-New Haven Hospital, New Haven, Conn.

With me on my right is Richard Knapp, the director of the Department of Teaching Hospitals, and on my left is Mr. Steven Summer, staff associate of the Department of Teaching Hospitals.

The association represents all of the Nation's medical schools, 62 academic societies and 400 of the Nation's major teaching hospitals. Our membership is thus deeply involved in both the provision of high quality medical services and the education and training of future physicians. The association is not supporting any specific proposal presently before the subcommittee, nor do we offer specific proposals.

A more detailed view of the association's position on national health insurance has been presented to the committee for inclusion in the record.

Mr. Rostenkowski. Without objection, it will be made a part of the record.

Mr. Womer. This morning I will limit my remarks to a discussion of the association's policy positions in the areas of health manpower, physician and hospital reimbursement, and the role of philanthropy as they relate to national health insurance.

HEALTH MANPOWER

National health insurance is an appropriate mechanism for financing graduate medical education—that is, the training of interns and residents—as a means of replenishing the health manpower pool. Public and private insurance programs as well as other patient care revenues are currently the predominate sources of financing graduate medical education and other hospital-based educational programs and should not be jeopardized. This method of financing graduate medical education has been historically applied both to inpatient and ambulatory or outpatient services. However, this financing has been much more adequate in the case inpatient services than it has been for outpatient services.

During the past several years, there has been substantial pressure, and subsequent institutional commitment to provide a greater amount of educational experience in ambulatory settings and to produce more primary care physicians. Generally, these commitments have been made without sufficient careful attention to longer range financial considerations.

For example, under the Manpower Act of 1971, a large number of family practice residency programs are being supported by Federal grant awards. In the absence of such awards, I seriously doubt these programs would survive.

The financing of all educational programs in the ambulatory setting is a difficult problem, and one which has not received the attention I believe it deserves. Facing continuing large deficits in the operation of their ambulatory services and diminishing ability to cover these losses from other revenue sources, teaching hospitals cannot significantly expand their ambulatory educational and service programs without adequate reimbursement for them. We would be happy to discuss it further with you when there is more time available than we have this morning.

In its financing of graduate medical education national health insurance may justifiably be used to influence the numbers and kinds of medical generalists and specialists that are trained. The problem of specialty distribution is currently under study by the Coordinating Council on Medical Education and the Institute of Medicine. The findings and recommendations of such studies should be carefully considered in developing methods for achieving a balanced supply of specialists which matches the public's needs for services.

PHYSICIAN AND HOSPITAL REIMBURSEMENT

Any national health insurance system must establish reimbursement policies which allow reasonable payments for services, and which stimulate efficiency and cost constraint consistent with the production of high quality medical services.

TEACHING PHYSICIAN REIMBURSEMENT

A fair and reasonable reimbursement policy for physician services should provide payment for high-quality medical services on an equal basis irrespective of the setting in which the services are provided. Such a reimbursement policy should not impede the training and education of medical students and residents, and should recognize the team approach to medical care in the teaching setting. The policy should not, for example, in setting conditions under which fee-for-service reimbursement of teaching physicians is to be made, require the financial tests or similar requirements imposed by section 227 of the Medicare Amendments of 1972. This entire issue is under study, at the direction of the Ways and Means Committee in 1973, by the Institute of Medicine. The association and its constituent institutions have actively cooperated in the development of this study, and I urge your thorough review of the final report when it becomes available in March of 1976.

TEACHING HOSPITAL REIMBURSEMENT

Payments to institutional providers must reflect the fact that there are valid differences among the various types of hospitals in the cost of delivering care. The cost of services delivered in the teaching hospital, for example, will be greater for at least three reasons: (1) the severity of illness and complexity of diagnosis which patients bring to the teaching hospital; (2) the comprehensiveness and/or intensiveness of services provided by the teaching hospital; and (3) the teaching hospital's commitment to the increment cost of providing the environment for medical and paramedical educational programs.

One of the most troublesome issues before us today is the manner in which section 223 of the 1972 Social Security Amendments has resulted in an inappropriate classification of hospitals for reimbursement purposes. We outlined our views concerning this matter to this subcommittee in June of this year and again in September. I will not take your time to do so again this morning. These views and a proposal which we submitted in September are available on the record, and again I want to express our willingness to discuss this matter further at any time.

PHILANTHROPY

Finally, I would like to turn to an important area which must be given careful attention in national health insurance deliberations. Philanthropic contributions have provided hospitals and medical schools with urgently needed support. Teaching hospitals, particularly, have relied upon philanthropy for support of new construction and innovative programs. This vital support has stimulated research and development in medical care organization, as well as research in the biomedical sciences. The association urges that members of this subcommittee continue to recognize and encourage the contribution of philanthropy to the health care system. The tax system should continue to provide deductions from corporate and individual taxes for charitable contributions. Additionally, hospital reimbursement policies should specifically provide that unrestricted endowment principal and income, donations, legacies, bequests and other charitable contributions not be included in formulas establishing payment rates. In some State rate control programs, and indeed during the Federal economic stabilization program, hospitals are being and have been threatened with failure to provide rate increases until after an institution's reserves and unrestricted endowment are depleted. The use of privately donated funds to meet operating costs is not a policy which encourages philanthropic giving. We recommend specific language be included in any national health insurance program to protect and encourage private philanthropy for health care institutions.

I have only highlighted our views, and have chosen to limit my remarks to a few narrow, but very difficult problems in the interest of brevity.

Thank you very much for permitting me the opportunity to testify before you on these very important issues. I will be happy to answer any questions you may have.

[The prepared report follows:]

AAMC Task Force on National Health Insurance

INTRODUCTION

The Association appointed the AAMC Task Force in National Health Insurance to revise the Association's policy statement on national health insurance dated February 18, 1971, in light of renewed Congressional interest in the issue. The members of the Task Force included Chairman James F. Kelly, Ph.D., Ray E. Brown, Jack W. Cole, M.D., Merlin K. DuVal, M.D., Baldwin G. Lamson, M.D., Alexander Leaf, M.D., G. Thomas Shires, M.D., John M. Stagl, Ernest Turner, and Robert L. Van Citters, M.D.

In its work, the Task Force first examined the present method of health care financing in the United States, assessed its deficiencies, and then determined what distortions in the present system of health care delivery were caused by the present system of health care financing. In light of these findings the Task Force proceeded to develop a set of recommended positions on various national health insurance issues. This report sets forth the Task Force's findings and recommendations.

FINDINGS

According to a recent Social Security Administration study, health spending in the United States in 1973 reached $94.1 billion. Funds to finance this health care bill came from three sources: (1) from individuals, as personal out-of-pocket medical expenditures; (2) from various forms of public or private insurance; and (3) from the general revenues, collected from taxpayers. In 1973, three-fifths of the nation's health care bill was paid from private sources, and two-fifths came from public sources. Total national expenditures for personal health care (excluding among other things expenditures for insurance premiums) totaled $76.5 billion in 1972 (the latest year for which data are available). Private health insurance met 25.5% of this amount, 35.6% came from direct out-of-pocket payments by consumers, and 37.5% was met by public funds.

Although health insurance met 42% of all consumer expenditures for personal health care in 1972, many individuals remained uncovered by any form of health insurance. In 1972, an estimated one-fifth of the population under age 65 had no financial protection against the hazards of illness. Still larger numbers had inadequate coverage. Three-fourths of the population had private insurance protection against some of the cost of hospital and surgical care; and 72% were covered for some of the cost of inpatient physician's visits and outpatient radiologic and laboratory examinations; about 55% were covered for any part of their expenditures for prescription drugs, private duty nursing or visiting-nurse services; 22% for any nursing home care; and less than 9% for any dental care.

These statistics illustrate that the portion of the health care bill which the individual must now pay directly as a personal expenditure is large. The purpose of a national health insurance program is to transfer a large part of this personal financial responsibility to the insurance function. Most of the financial risk of illness should be shared by all in an approximately equal way through the insurance mechanism.

The major purpose of national health insurance legislation, then, is to create a better means of financing medical care. Although national health insurance per se may not effect a drastic restructuring of the health care delivery system, it should promote needed changes. To define and then bring about the ideal delivery system is too great a task to be accomplished in a single step. Yet national health insurance should both permit and strongly encourage changes in the present delivery system.

Accordingly, the Task Force makes the following findings of deficiencies in the present system of health care financing:

(1) It acts as a barrier to accessibility to needed health care services.

(2) It leaves too many uncovered costs to be borne inordinately by the individual as personal out-of-pocket expenditures.

(3) It promotes and perpetuates a two-class system of patient care.

(4) The insurance component, unlike other insurance, does not cover the highest risks first, and often does not cover them at all.

Further, the Task Force makes the following findings of distortions in the present health care delivery system under the present health care financing mechanisms:

(1) It interferes with professional judgment as to the use of expensive patient care where less expensive patient care would be appropriate.

(2) It offers few incentives for efficiency.

(3) It does not stimulate changes in the present delivery system.

(4) It does not provide the risk capital necessary for innovation.

(5) It stimulates the disproportionate distribution of health care resources to more affluent areas.

(6) It provides inadequate financing for the provision of health services to the poor.

(7) It provides inadequate incentives for distributing physicians by specialty according to the needs of society.

In light of these findings, the Task Force takes the following positions on the specific national health insurance issues of *scope of coverage, structure of covered benefits, consumer responsibility for cost-sharing, methods of financing the insurance system, regulation of the underwriter, regulation of providers, standards for provider reimbursement, development and distribution of resources,* and *effect on other programs.*

SCOPE OF COVERAGE

Because adequate health care has come to be recognized as a right and not a privilege of all Americans, any national health insurance system should have as its first priority the provisions of health insurance coverage for all. This goal of universal coverage will be attained by requiring as a matter of law not only that the opportunity to obtain adequate health insurance coverage must be made available to each individual, but also that he must take advantage of this opportunity. Voluntarism will never produce universal coverage, for there will always be those who will opt out due to ignorance, undue optimism, or neglect. A national health insurance program which does not provide universal coverage will unquestionably perpetuate the two-class system of patient care it is designed to eliminate, as afflicted individuals without health insurance protection will have to be treated on a charity basis.

BENEFIT STRUCTURE

A national health insurance plan should finance the most comprehensive package of health care benefits within the resources available. As a general rule, all necessary health care expenditures should be covered without quantity limits. Exclusion from coverage should be well-defined and well-reasoned. All exclusions should be periodically reviewed and re-evaluated in light of new federal initiatives and new developments in health care management and delivery. Any exclusion from coverage should fit into one of the following categories:

(1) Services for which insufficient personnel and facilities exist for provision on a universal basis should be excluded. It would be irresponsible for the national health insurance legislation to create health care expectations that the delivery system could not meet.

(2) Services not traditionally included in an individual's personal health care expenditures, and financed instead through general revenues as public health care expenditures, although important to good personal health, should initially be excluded from coverage under national health insurance. Because long-term care for chronic mental illness, for example, is most often provided in state-operated institutions supported by public funds, this care would most efficiently be provided with federal assistance and in accord with federal quality standards through a separate state-operated system. The Medicaid program, which now finances long-term custodial care in nursing homes in many

states, should be modified to have as its primary purpose the provision of this kind of care in accord with federal quality standards in all states for individuals who cannot pay for it as a personal health care expenditure.

(3) Benefits which, if included, would pose unreasonable administrative burdens should be excluded from coverage under the national health insurance system.

Except for services excluded for these reasons, covered services should include, at a minimum and without limit, hospital services (including active treatment in psychiatric hospitals), physician services and other appropriate professional and paramedical services wherever provided, and diagnostic laboratory and diagnostic and therapeutic radiologic services wherever provided. Other covered benefits should include wherever provided such services as home health services, rehabilitation services, cost-beneficial preventive services, emergency medical services, and crisis-intervention mental health services.

COST-SHARING

A program of national health insurance is designed to provide ready financial access to the health care system and to shift the financial burden of health care from personal expenditures to insurance coverage, thus broadening the financial base available to support health care costs. The ideal health insurance program should therefore have no cost-sharing provisions. If a particular health insurance proposal includes such cost-sharing mechanisms as deductibles, coinsurance, or copayments, they should be held to minimum levels, and their effect on utilization should be evaluated. They should only be high enough to avoid over-utilization; they should not be burdensome in the aggregate to a family; they should be waived for low-income persons. Furthermore, they should not be applicable to essential minimum services, and the cost of administering the cost-sharing should not exceed the savings from avoided over-utilization. In addition, if a national health insurance plan utilizes cost-sharing, the provider, in order to promote efficiency, should not be involved in collecting the patient's share. The provider should not be required to determine at the point of delivery whether or not the patient has met cost-sharing obligations in the past or whether the patient can pay any new cost-sharing obligations that may arise.

FINANCING THE INSURANCE SYSTEM

The present system of health care financing leaves significant population groups without health insurance protection, and even larger groups with inadequate coverage. The individual's personal, out-of-pocket health bills too often exceed his financial ability to meet them and act as a barrier to needed care. Health insurance should meet more of the individual's health care expenses. The method used to finance the national health insurance system should mandate universal coverage and make certain that individuals are not caught in gaps of coverage with changes in employment or financial status. Each and every citizen must be assured of a uniform minimum package of benefits.

REGULATION OF THE INSURANCE UNDERWRITER

Regardless of the extent to which private health insurance is to be included in a national health insurance program, the federal government has a responsibility for safeguarding the public by effectively regulating the private insurers. Such regulation will be most effective if done by a single federal agency, independent of the agency charged with administering the national health insurance program, which will license, monitor, and otherwise regulate all health insurance underwriters. This agency should also be charged with the duty to promulgate standards governing carrier solvency, risk-selection, loss ratios, and premium rates.

REGULATION OF THE PROVIDER

Any regulation of the relationship between the underwriter or the intermediary and the provider must assure that the standards by which providers are reimbursed for their services are not only economically prudent but also fundamentally fair. Because there are substantial area-to-area variations, the regulation of provider reimbursement and health care costs would best be performed at the state or substate level under strong federal guidelines. Regulatory decisions in these areas must be rendered with due process, equity, and fairness, and there should be an effective mechanism for the appeal of such decisions.

PROVIDER REIMBURSEMENT STANDARDS

Any national health insurance system must establish a reimbursement policy which allows fair and reasonable payments for services and which stimulates efficiency and cost constraints as consistent with the promotion of high quality medical care.

A fair and reasonable reimbursement policy for physician services should provide payment for high quality professional medical services on an equal basis irrespective of the setting in which the services are provided. Such a reimbursement policy should not impede the training and education of medical students and residents, and should recognize the team approach to professional care in the teaching setting. The policy should not, for example, in setting conditions under which fee-for-service reimbursement of teaching physicians is to be made, require the kind of financial test and other conditions imposed by section 227 of the Social Security Amendments of 1972.

A reimbursement policy which is fair and reasonable also will meet the financial needs of the institutional providers of the services, including the replenishment of capital for the maintenance of an up-to-date facility. Allowable expenses for reimbursement under a national health insurance program should include the depreciation of capital assets, the amortization of debt, and the accumulation of an adequate operating margin. Furthermore, the reimbursement policy should reflect that there are valid differentials among the various types of providers in the cost of delivering care. The cost of services delivered in the teaching hospital, for example, will be greater for at least three reasons: (1) the severity of illness and complexity of diagnosis which patients bring to the teaching hospital; (2) the comprehensiveness and/or intensiveness of services provided by the teaching hospital, and (3) the teaching hospital's commitment to the incremental cost of providing the environment for medical and paramedical educational programs.

A reimbursement policy that stimulates efficiency and cost constraints consistent with the promotion of high quality medical care will not only mandate that the providers institute effective utilization review and quality control programs. It will also provide for an organized system of research and development of methods to insure that quality control and utilization control standards will be determined and implemented only on a valid statistical basis. Furthermore, because provider efforts to regulate and monitor quality and utilization are costly propositions, the cost of any such regulatory measure should be justified by its effectiveness and then treated as any other allowable cost for the purpose of reimbursement.

RESOURCE DEVELOPMENT AND DISTRIBUTION

While national health insurance should not be expected to correct all of the distortions in the present health care delivery system caused by the current system of health care financing, neither should its reimbursement policies encourage further distortions.

National health insurance is an appropriate mechanism for financing graduate medical education as a means of replenishing the health manpower pool. Graduate medical training includes important elements related to education and delivery of health services as integral parts of the training, and is thus appropriately financed by the health delivery system, both with respect to inpatient and ambulatory care. In its financing of graduate medical education, the national health insurance system may justifiably be used to influence the numbers and kinds of medical generalists and specialists that are trained. The problem of specialty distribution is currently under study by the Coordinating Council on Medical Education and the Institute of Medicine, and the findings and recommendations of such studies should be carefully considered in developing a method for dealing with the problem.

Similarly, national health insurance is an appropriate mechanism to assure the construction of resources that meet community needs. The special need for facilities for the education and training of health professionals by the medical schools and teaching hospitals must be given proper recognition in these determinations. The kind of approach to this problem taken by Section 1122 of the

Social Security Act, which provides that providers constructing facilities determined to be unnecessary by a state's designated planning agency are not to receive federal reimbursement for depreciation and interest on those facilities, should be extended to reimbursements under a national health insurance program. Planning agencies should be strengthened to perform this additional function.

PHILANTHROPY

Philanthropic contributions have provided non-profit and public hospitals with urgently needed support. Teaching hospitals, particularly, have relied upon philanthropy for support of new construction and for innovative programs. This vital support has stimulated research and development in medical care organization.

Any program of national health insurance should recognize and encourage the contribution of philanthropy to the health care system. More specifically the tax system should continue to provide deductions from corporate and individual income taxes for charitable contributions. Second, hospital reimbursement formulas should specifically provide that unrestricted endowment principal and income, donations, legacies, bequests and other charitable contributions not be included in formulas establishing payment rates. Finally, expenditures of funds derived from philanthropy should be under the control of the governing board of the respective hospital subject only to the control of the state planning agency.

EFFECT ON OTHER FEDERAL PROGRAMS

The federal government should have a coherent, rational, and unified role in the financing of health care. To date, public health care funds have been channeled into a variety of inadequate or overlapping federal programs, and the resulting fragmentation has been both costly and inefficient. Accordingly, separate federal programs that now exist, such as the Veterans Administration health care system, Public Health Service hospitals, the Indian Health Service, and the military dependents program, should be integrated into the national health insurance system. This integration will best be accomplished gradually, but nonetheless in accordance with a fixed timetable. To this end, the first priority should be the standardization of all benefits provided through all existing public programs to conform to the national health insurance benefit package standard. As this is accomplished, the other aspects of the separate public health care programs should be modified and meshed into the national health insurance system. If a program cannot feasibly be modified for integration into the national health insurance scheme, it should be gradually phased out.

Mr. ROSTENKOWSKI. Thank you, Mr. Womer.

What percentage of charitable giving would you think is contributed with respect to the continuing operation of hospitals?

Mr. WOMER. There is practically no charitable giving for operating purposes of hospitals—that is to meet the costs of providing care, except in some very narrow areas in particular institutions. In other words, in the institutions I represent, money was given back in 1890 to provide care for tuberculosis patients, but most of the charitable giving, the vast bulk of it, is either given on an unrestricted basis, or restricted to specific construction programs for development of new programs or for research. I cannot give you a figure, though, Mr. Chairman, across the country.

Mr. ROSTENKOWSKI. Mr. Duncan.

Mr. DUNCAN. Thank you.

Mr. Womer, recently, in the last 2 or 3 weeks, there was an article in the newspapers and in the press generally that had some criticism of teaching hospitals, that they were charging extra administrative costs and other things, which actually, in the end, the patient was paying for. Would you care to respond to that?

Mr. WOMER. I do not recall the specific article. I do not think the teaching hospitals have extra administrative costs. The teaching hospitals do have educational costs, and these educational costs by and large are indeed paid for by reimbursing parties such as Blue Cross, or insurance plans, or are incorporated in the hospital rate structure for payment by patients who pay for their own care.

Mr. Duncan. Are you aware of the charge that the teaching hospitals are padding their bills to those who provide the funds for operation?

Mr. Womer. I am not aware of any padding. I am aware that in their rate structures, many teaching hospitals have to play a Robin Hood game. Using Yale-New Haven as an example, we have to in effect overcharge the inpatient who is paying his own bill to cover our very significant deficits in the operation of our ambulatory services.

This is because the reimbursement programs for ambulatory services are so inadequate.

Medicaid, for instance, will pay the cost of a hospital providing inpatient services, but there is no such requirement that they pay costs for outpatient services, and in most instances they do not.

In the case of Yale-New Haven, it means that we in effect overcharge patients $1.5 million a year on the inpatient services to make up a deficit of $1.5 million a year in outpatient services.

Mr. Duncan. Do you have a specific suggestion with regard to how national health insurance might be used to influence the number and kind of medical generalists and specialists that are trained?

Mr. Womer. Well, I think this can be done in a number of ways. I really think, though, that this is more appropriate to the health manpower legislation which is before the Congress at the present time, than it is to national health insurance.

National health insurance might, through its reimbursement policies, shall I say, have controls that would tend to guarantee that the objectives of the health manpower legislation in relation to maldistribution of physicians, both by specialty and geographically, are addressed.

For example, if I may use one, if it is determined that we should be training so many people in given specialties, in a given region of the country, I would assume that national health insurance would not pay for costs associated with training more than that given number of people in that region of the country.

Mr. Duncan. My time is up. Thank you very much. Thank you, Mr. Chairman.

Mr. Rostenkowski. Mr. Cotter will inquire.

Mr. Cotter. No questions.

Mr. Rostenkowski. Mr. Waggonner will inquire.

Mr. Waggonner. Thank you, Mr. Chairman.

On page 2 of your statement with respect to health manpower, you say that generally these commitments have been made without sufficient attention to longer range financial considerations, and you go on to explain the Manpower Act of 1971, providing some assistance for family practice residencies, which, of course, are supported by Federal grants.

You make the statement that in the absence of such awards, you seriously doubt that these programs would survive.

I really want to know what you mean by that statement. Are you just saying that unless you get Federal assistance that family practice residencies would be done away with?

Mr. Womer. I am saying that the awards are supporting these programs at the present time. If these awards were discontinued, in the absence of adequate reimbursement for these programs in other ways, that the programs could not survive, because these programs are largely based in the ambulatory setting, and for the reasons that I stated before, the institutions cannot take on additional commitments.

Now, if the cost of these commitments were to be incorporated in the reimbursement program for ambulatory care, that is another matter, but I am speaking in the absence of other methods of funding.

Mr. Waggonner. Is there, to a degree, a comparable situation with respect to every other residency, other than family practice?

Mr. Womer. At the present time, most reimbursement programs will reimburse an institution, with certain limits, for its costs, which include the cost of residencies on the inpatient services. Most other residencies are largely located on the inpatient services, and reimbursement formulas are much more adequate in covering the costs of the inpatient services than they are in the ambulatory services.

Mr. Waggonner. What about a per capita grant. How do you justify not spending some of that money on family practice?

Mr. Womer. The per capita grant?

Mr. Waggonner. To medical schools.

Mr. Womer. If you are talking about the so-called capitation grant to medical schools, this is designed to cover the cost to the medical school, a portion of the cost of undergraduate medical education, which is different than the cost of graduate medical education which takes place after the person has been awarded the M.D.

Those funds do not flow from the medical school to the hospital any more than funds provided to the hospital for providing care to patients flow to the medical school to cover educational costs.

One is an undergraduate program and one is a graduate program.

Mr. Waggonner. On page 7 of this report, which you attach to your statement, having to do with financing the insurance system, you make a general statement that the method used to finance the national health insurance system should mandate universal coverage.

How do you recommend that this system be financed?

Mr. Womer. Sir, I would be presumptuous to recommend any particular system of financing. This is beyond the scope of the association's objectives. I think there are as many preferred methods of financing as there are people testifying.

When we say that the method to finance should mandate universal coverage, we are saying there that it should mandate that every person in this country is covered, without exclusion. That is all we are saying. It doesn't have to do with level of benefits, but just that all should be covered.

Mr. Waggonner. That is a problem we are running into already everywhere. When we ask someone how they would pay for the proposal, most of them take the position you do: "That is your problem. You are Members of Congress."

So it is easy for you people to come down here and ideally talk in general terms about how nice it would be if we would provide for all these things and let somebody else worry about paying for it. But we are going to need assistance in that direction, too. So you all are going to have to quit passing the buck at some point in time. You are going to have to tell us what you recommend in this respect, too.

Now, you tell us what you have to have in the way of money to continue to do certain things. You have to tell us where we are going to get this money, too. That is our problem. It is a practical problem.

Mr. WOMER. Yes, sir. Obviously it has to come out of governmental revenues somehow, or out of conditions mandated on employers or a combination of same.

I am not trying to dodge the issue. Obviously the method of funding is closely tied to scope of program, and the cost of the program is closely tied to its scope. I don't think that you can discuss either the financing or the scope or the sources of revenue in a vacuum, one apart from the other.

It is a large actuarial problem which is beyond my expertise.

Mr. WAGGONNER. Thank you.

Mr. ROSTENKOWSKI. Mr. Womer, thank you very much.

Welcome to the subcommittee, Mr. Lewis. Identify yourself, your organization, and you may proceed with your testimony.

STATEMENT OF ALFRED BAKER LEWIS, NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE AND HEALTH SECURITY COUNCIL OF CONNECTICUT, ACCOMPANIED BY BETTY DOLLEY AND MRS. GALATY FROM THE HOUSE SECURITY COMMITTEE

Mr. LEWIS. Mr. Chairman and gentlemen, I have with me Mrs. Galaty and also Mrs. Betty Dooley from the House Security Action Committee. I want to call your attention to the fact that I am the only witness who has come before you who has had intelligence enough to know that women, too, are interested in health care.

My name is Alfred Baker Lewis, and I am testifying on behalf of the National Association for the Advancement of Colored People and of the Health Security Council of Connecticut in support of the Kennedy-Corman bill.

We need free hospital and medical care for everyone through a system of national health insurance. We should have the best health care in the world, because we spend more money on medical research than any other country. Probably we have the best medical and hospital care for those comparatively few who can pay for it. But too often it is not available to those who need it. An important reason for this failure to deliver the best health care for everyone is the cost to the individual person who becomes sick or injured in a nonindustrial accident (industrial accidents are already covered by workmen's compensation). The cost of medical and hospital care has risen in the last few years higher and faster than other components in the increasing costs of living.

Good health care should be the right of any inhabitant of our country, just as the chance to get an education is a right.

The gentleman over here asked if the witness felt food should be a right, and the answer is that we do treat food as a right for everybody through our Public Welfare System. Yet, our citizens do not have health care as a right, and the care they get is not as good as it should be.

There are two proofs of that last statement.

The best test of good health care is infant mortality. If we had the best medical care of any country, we would have the lowest infant mortality. We don't. We are 18th from the lowest, and nearly every country with lower infant mortality than ours has some form or other of Government health insurance. This is a fact which we cannot ignore. We must face it. To ignore it, as do the opponents of Government health insurance, can only be done at the expense of the Nation's health.

The second proof is that Negroes have a substantially higher rate of infant mortality and a lower rate of longevity by 10 or 11 percent than do whites. This is clearly due to the lack of proper delivery of health care to those who need it. For Negroes are basically as healthy and hardy as whites if not more so. If you doubt that, you have only to look at the figures for the Olympic games, and their performance in professional ballgames.

In the 1964 Olympics, one college, Tennessee A. & M. in Nashville, with 10,000 Negro students, had 7 gold medalists. No other college had more than one gold medalist except the University of California, which has some 90,000 students, over 90 percent of them whites; and it has two gold medalists. No other college in the country had more than one gold medalist.

When 10,000 Negro students turned out 7 gold medalists and nearly 90,000 white students won 2 gold medals, no one can say that Negroes are not healthy and hardy. They are. If they don't live quite so long—and they don't—and have a higher infant mortality rate than whites—which they do—it is because of the harder economic conditions under which on an average they have to live, and part of these harder economic conditions is poorer medical care.

The 1968 Olympics told the same story. The proportion of Negro to white gold medal winners on the American team was higher than their proportion to the general population.

It has been argued that we should maintain our present medical system, which is mainly on a fee for service basis, because we have made progress in increasing health and longevity. That is true. We have made such progress. The countries, however, which have Government health insurance have also made such progress and at a greater rate than we. We are now 18th from the lowest in infant mortality. Fifteen years ago we were 9th from the lowest. While we have made progress in reducing infant mortality and increasing longevity, the countries with government health insurance have made greater progress. The figures are given in exhibit A.

ARGUMENT ABOUT COST

The big argument used by the opponents of having free hospital and medical care for everyone is the cost. The argument is fallacious. It would add to the Federal budget. But every penny added to the Federal budget would be taken off the budgets of those who now pay somehow for hospital and medical care. There is absolutely nothing in Government health insurance that will increase the total social cost of health care, though it will add to the Federal budget. The inhabitants of our country already bear in full the cost of illness and nonindustrial accident. If a person becomes sick, the cost is borne by him if he can afford it. His family pays part of the cost for he may have to draw on his savings for his old age or for the higher education of his children. His employer suffers the loss of his work, and in a sense the whole community loses from the loss of his productive labor. Some of the financial cost may be borne by an insurance company, which means in the long run by the premiums of the policyholders. If he is indigent, or the illness forces him to become so, the State and local taxpayers, who pay for public welfare relief, carry the load. The cost is there. Someone in the community pays it. All that national health insurance does is to distribute the cost around in a more just and equitable manner.

Part of the trouble with health care now is that the availability of it is very unevenly distributed. If you live in a poor community the chances are that there is not good medical care readily available even if you can afford it. Most physicians, like others, want to live and practice where the money is. So poor communities have far fewer doctors or dentists in proportion to the population than richer ones.

We recognized this fact by trying to stimulate the building of hospital and health centers in places which lack them through the Hill-Burton Act. This has reduced somewhat but not eliminated the present maldistribution of medical care.

If you are unfortunate enough to be on relief, the situation is worse. Most relief costs are paid for by local taxes, mainly real estate taxes, with some subsidies from the State governments. This means, if relief is to be adequate, that the poor would have to be taxed heavily to support the destitute living among the poor, of whom there are many; while wealthier persons living in richer communities are taxed only lightly to support the destitute living among the rich, of whom there are few. This clearly is unjust. Also, it intensifies the maldistribution of medical care because the poorer localities simply cannot pay the taxes to provide adequate relief including medical care for those who need it and cannot pay for it.

Government health insurance would transfer the cost of sickness and nonindustrial accidents for persons on relief from the State and local taxpayers, who now pay most of the cost of general public welfare relief, to the Federal Government. This would be a gain in social justice. For the States raise most of their money by sales taxes. Sales taxes bear much more heavily in proportion on the poor than on the rich. Nearly every penny spent by a poor person is hit with a sales tax. But many expenditures typical of a rich family totally escape a State sales tax, such as expenditures for domestic service, for trips abroad, or for investments. The local government bodies raise most of their money by taxes on real estate. This hits small homeowners. It also hits all tenants, because the landlords add the cost of the taxes to the rents. Taxes on real estate are not an accurate reflection of wealth, and therefore of ability to pay. For most of the wealth of rich people is held in the form of stocks and bonds, which are intangible personal property, and which the taxes relied on by local governments hardly ever reach. The Federal Government on the other hand raises most of its money from the graduated personal income tax and the corporation profits tax. Despite loopholes favoring the rich in these taxes, which your committee has been trying to eliminate, but has backed down on to some extent, according to the newspapers. The Federal Government's tax system is, roughly, taxation in proportion to ability to pay.

GOVERNMENT HEALTH INSURANCE WOULD REDUCE THE COST OF HEALTH CARE

There are sound reasons why the social cost of medical care would almost certainly be less under a system of Government health insurance than it is now. Where a person carries health insurance, the health insurance provides money to the doctor provided the patient is hospitalized. So, in a good many cases doctors hospitalize patients so they will get money from the insurance company which they otherwise would not do.

Too many people, when they begin to get sick, put off going to the doctor because of the expense. Inevitably, when they finally do have to go, the disease is apt to have a stronger hold and the cure is likely to take longer and cost more than would have been the case had he or she sought medical care earlier. If they could get medical care by Government health insurance without personally paying for it through the fee-for-service system, they would be less likely to put off going to the doctor until too late.

PRESENT ACCIDENT AND HEALTH INSURANCE COSTS ARE FAR TOO HIGH

I happen to know something about that, because I was connected with a private health insurance company.

A good deal of accident and health insurance costs are now carried by private insurance companies. Most of the policies are not sufficiently comprehensive. Some are only for disaster insurance, paying the cost of hospitalization if it goes above a certain fairly high level. Nearly all the group insurance policies that I know exclude mental illness and dental care. Nearly all individual policies exclude the cost of care for illness growing out of a preexisting physical condition. The cost of maternity coverage is very high for those in the marital and age bracket that need it most.

Above all, all the policies are unnecessarily expensive because of the high competitive acquisition costs. The acquisition costs are mainly advertising expense. They are totally unnecessary from a social point of view, and would be eliminated entirely by national health insurance.

You can get some idea of the unnecessary cost of health insurance carried by private companies from the figures on the relation between premiums and benefits collected and paid by private insurance companies.

The figures given in the "Statistical Abstract of the United States for 1974" on page 464 show that the benefits paid out by private insurance companies were around 75 percent of the premiums taken in. For Blue Cross and Blue Shield, however, where the competitive acquisition costs do not exist so that they are in this respect similar to Government health insurance, the benefits paid out were 93 percent of the premium income.

Government health insurance is needed: it would reduce the total social cost of illness and nonindustrial accidents; it would cover practically all the medical and hospital costs of ill health, which private insurance companies don't do; and it would distribute the cost of health care in a more equitable way.

BRIEF CRITIQUE OF OTHER BILLS

There are a number of other bills on health insurance before Congress. They are not satisfactory to those who favor full health care for all through the Kennedy-Corman bill for two main reasons. First, they do not fully cover health costs. For the costs that they do cover, they have coinsurance of 20 or 25 percent to be paid by the sick person plus deductibles of $150 which must be paid in full first by those getting health care before they get benefits. The only bill that does not have these is the Kennedy-Corman bill. Good health care is a right, and should be so treated. There is, therefore, no more reason to require those who need medical or hospital care to pay part of the cost when they need it than there is to require those who have children in school to pay directly part of the cost of their children's education. In both cases the cost should be covered by taxes.

I will not go into the figures on infant mortality compared with the United States and other countries, except to call your attention to the fact that one oriental country, Japan, and one Communist country, East Germany, and even Spain, has a lower infant mortality that we do, and they have national health insurance.

Are there questions?

[Exhibit A follows:]

EXHIBIT A

[1974 Ency. Brit., p. 727—Infant Mortality Rate]

United States	18.5
Hong Kong	17.5
Japan	12.4
Denmark	14.2
Finland	11.3
France	16.0
East Germany	18.0
Ireland	18.0
Luxembourg	13.6
Netherlands	11.4
Norway	12.5
Sweden	11.1
Switzerland	14.4
United Kingdom	17.6
Canada	17.5
Australia	17.3
New Zealand	16.5
Spain	16.0

We are 17th from the lowest.

[1959 Ency. Brit., p. 106]

United States	26
Denmark	23
Netherlands	17
Norway	21
Sweden	17
Switzerland	23
United Kingdom	23
Australia	21
New Zealand	20

We were 9th from lowest.

Mr. Rostenkowski. Thank you, Mr. Lewis.

Are there any questions of Mr. Lewis?

Mr. Cotter. No; I would like to compliment Mr. Lewis on the very thorough statement.

Mr. Lewis. Thank you.

I am sorry the young lady wasn't here when I remarked that I, alone, recognize that women are interested in the national health insurance.

Mrs. Keys. Thank you, Mr. Lewis.

I will read your testimony, and it was a pleasure to hear the end of it.

Mr. Rostenkowski. Mr. José García Oller and Mr. Hyman.

Gentlemen, if you will identify yourselves and the organization, you may proceed with your testimony.

STATEMENT OF JOSÉ L. GARCÍA OLLER, M.D., PRESIDENT, AND EDWARD S. HYMAN, M.D., SECRETARY, AMERICAN COUNCIL OF MEDICAL STAFFS

Dr. Oller. Thank you, Mr. Chairman, members of the committee.

I am Dr. José García Oller, and with me is Dr. Edward S. Hyman.

Do the members of your committee have a copy of our printed testimony before you? We have extra copies.

Mr. Rostenkowski. Yes; we have the copies of the testimony.

Dr. Oller. Second, Mr. Chairman, we have some additional documentation for reference that we have prepared in these folders for each of the members, too, in view of the short time on this presentation, so you will have documentation for you and your staff to study.

Mr. Rostenkowski. Your supplementary material will be filed with the committee, Dr. Oller. Your statement will be inserted in its entirety in the record.

Dr. Oller. Yes, and I have here these additional documents. I will submit those and they will not be for the record, because they are available otherwise.

Mr. Rostenkowski. Thank you.

Dr. Oller. So, quickly, Mr. Chairman, the testimony starts with a national health policy. Thereafter, we have our recommendations, and then the testimony itself on page 1, where I shall begin. With your kind permission I will skip those areas where a reading of the testimony might suffice.

INTRODUCTION

Mr. Chairman, members of the subcommittee, I am Dr. José L. García Oller, president and founder of American CMS, the American Council of Medical Staffs. I have limited my private practice to the field of brain surgery for the past 25 years, and for 15 years served the indigent as head of the independent neurosurgery unit at Charity Hospital in New Orleans. I am a graduate of the Jefferson Medical College in Pennsylvania, class of 1945. With me is Edward S. Hyman, M.D., secretary of American CMS. A 1946 graduate of the Johns Hopkins medical school, he is a privately practicing specialist in internal medicine for 22 years, and a research biophysicist.

CMS FOUNDED IN 1968

CMS was founded in 1968 as a unique grassroots organization designed to obtain the votes of private doctors. This was achieved by organizing through the existing medical staffs of community hospitals—nonprofit or for profit. Because attendance is required at staff meetings, we can obtain consensus through regular votes on issues.

Our recommendation for a national health policy is set forth for your study in the printed testimony:

1. Personal, individualized care of high quality, with dignity and privacy, at a cost to the citizen on the basis of a patient-physician agreement is the hallmark of the American system of private medicine. Its continued and expanded availability under free enterprise is the proper goal of our national policy on medical care.

Here I would comment that we would like to see the high dignity system extended to the poor.

2. The citizen's right to choose his private doctor, to receive medical care in accordance with his physician's best judgment, and the physician's right to administer it, must not be limited.

3. These decisions are inherent in the practice of medicine: The care, diagnosis and treatment and the admission and discharge of patients from hospitals and facilities. They are to remain the prerogative of the patient's attending physician, not of Government or insurance companies.

There shall be no Federal intervention in the private practice of medicine such as: control of admissions by Government committees; treatment of the sick dictated through Government-approved manuals; length of stays in a hospital imposed by computerized averages; and denials of "necessity of hospitalization" determined by Government carriers who have never examined the patient.

A. PSRO—RATIONING OF MEDICAL CARE

PSRO, "sold" as a "cost control" mechanism for national health insurance by the Nixon administration, is in fact a full-scale rationing system which does violence to the principles of the patient's right to privacy and choice of treatment and the physician's right to individualized judgment.

B. INVASION OF PRIVACY, RATIONING OF ADMISSIONS, FEDERAL RULEBOOK

1. Section 1155(b)3 says that PSRO may examine the medical records of patients. 2. Section 1155(a) provides that for anyone requesting admission to the hospital, a committee will look at his "papers" and decide whether that patient is eligible for hospitalization.

3. A Federal rulebook for the diagnosis, care, and treatment of all diseases.

Under section three we give you an example:

C. THE COMMON COLD TREATED BY PSRO-TYPE GUIDELINES

Mr. Chairman, people want to know how PSRO is going to save money as a cost-control mechanism. We have printed for you the official testimony of the San Joaquin Foundation for medical care, where it gave to the Senate Finance Committee examples of numerous guidelines for treatment. We chose their No. 1, the treatment of the common cold. On the left-hand side on page 4, we reproduced the recommendations of the San Joaquin Foundation for medical care (and how our national health service could treat a common cold under PSRO):

We have estimated the cost of the treatment of the common cold under the classic San Joaquin formula on right-hand side on page 4: the PSRO cold would cost $41 for treatment. And for the population we have estimated $34 billion, which is 1.6 times as much as all physician's bills in the country, and we have already used it up in the treatment of the common cold.

I would submit that this is not our recommendation, Mr. Chairman. This is the San Joaquin Foundation's record from the Senate testimony.

CMS has filed a brief on PSRO as amicus curiae in the AAPS suit. We have also filed suit on the PSRO-type Utilization Review Regulations of November 19, 1974.

The second problem we would like to mention to you on the regulation of disease, Mr. Chairman, is this:

A few years ago, the Bureau of Health Insurance, as described under section E of our testimony, and as shown in our appendix B on page 21, issued a ruling for medicare, that the insurance carrier is to determine the "reasonableness and necessity of a general anesthetic" on a patient, who is undergoing a cataract operation, and that the insurance carrier "will determine the reasonableness and necessity of an assistant surgeon in cataract surgery".

In appendix B, we have a photostat of that ruling that has been issued by medicare, that gets into every operating room in the country and tells the doctor that he cannot put his patient to sleep for one of the most serious operations that we have, and certainly one of the most complicated. This direct intervention in the practice of medicine, wherein the bureaucrat can make a ruling to determine the issues of life and death, is frightening.

On page 5, therefore, our recommendations:

(1) We believe that the PSRO law should be repealed.

(2) We believe that the benefits of any Federal program should be uniform throughout the country, from New York to California, to Louisiana.

(3) We believe that the recent medicare ruling on cataract surgery must be overruled.

(4) The next part of the presentation is a socioeconomic summary, Mr. Chairman. We have heard of "health crisis" for quite a few years. I assume that many of us have seen the latest Time magazine (and it is one of the enclosures that I have provided the committee members), that is on the newsstands now, on page 68 is the article "Doctors Revolt"; where 15,000 doctors in Britain are now going into their first strike. In the third column there is a statement by Dr. David Owen, Minister of State.

He says, "The health service was launched on a fallacy. We were going to finance everything—cure the nation and spending would drop. That fallacy has been exposed. Now we realize that no country, even if prepared to pay the taxes, can supply everything." This, of course, is a fundamental fallacy, similar to that presented this morning under testimony on the Health Security Act.

Namely, the concept, Mr. Chairman, that we should confiscate the $100 billion of health moneys, including those that private citizens use, and have the Government give superior wisdom and guidance to that money. If we apply that to every endeavor, such as the construction workers' industry and we give the Government the ability to dole out the apartments and the homes, I don't believe that would be supported by Mr. Meany.

The nine fallacies of the so-called health crisis are covered on pages 5 through 13 of your testimony—I will not go into detail on this because of the time limitation. The first fallacy is that medical care costs and physicians' fees have risen twice as fast as the Consumer Price Index. We have here on page 6 the classic Fortune magazine illustration exposure in 1970.

The fact is that, if you compare the services CPI with the medical care CPI, the rise is identical. The point, then, is that there has been a fallacy in comparing medical services to goods, rather than to services.

The second fallacy is that physicians' fees are spiraling above the economy. We have a 13-year review from Professor Meyers' book shown on our figure 3, where physicians' fees have risen less than average wages in covered employment.

Fallacy No. 3, is that prescription drug prices are escalating. On page 8 we have a study showing that prices have decreased for the last 14 years. We believe that is a very unjust fallacy and accusation.

Fallacy No. 4, "the runaway costs of hospital care—and what we need is a federally regulated system." We point out that we have a wage-intensive industry with repressed wages. We all know that they had to "catch up" under minimum wage laws. We must recognize the cost of technological progress, which means dollars, but we also recognize the "blank check" of insurance coverage. Capable witnesses before us have appeared who have covered the "blank check" influence on the escalating costs of hospital care.

However, we find out that the national health insurance in this country would multiply that problem manifold.

Our recommendation is that if we are to moderate the escalation in Federal and other insurance programs in hospitals, we have to eliminate "first dollar coverage" in medical care.

If we have "first dollar coverage," giving equal access to the well and the unwell, we have no choice but to ration the services based on denials of services or onwaiting lines, or on decreased quality.

We believe, therefore, that if we are to have a rational system, there should always be a degree of personal financial responsibility of the patient, whereby the patient communicates his consumer choice.

Therefore, there is, in our opinion, no way to contain costs unless we have, (1) elimination of "first dollar coverage"; and, (2) direct billing, whereby the patient gets the reimbursement and the patient pays or doesn't pay the doctor according to patient satisfaction. This would keep the doctor's loyalty to his patient instead of to the insurance, the Government, or a computer. We believe the direct billing is essential in the care of the indigent. We believe it is time to give the indigent first-class medical care. Pay the patient and let him decide whether the doctor is worth paying or not—we will have the regulation of the marketplace we need.

The high cost of claims review for small bills would in fact constitute deductible payment.

The average American prescription is $4.50 this year. The review cost of that prescription would also be $4.50. We are paying double.

The medicare program is rapidly becoming a papercare program, with the preoccupation for the care and feeding of the forms and the computers to satisfy Government rules; entire new departments have arisen in hospitals; there are more people in the business office than in laboratories; personnel proliferates with a massive featherbedding of questionably useful personnel and activities which are paid for by medicare.

With the promise of medicare reimbursements, public relation departments have sprung like an epidemic; parking lots proliferate; beautiful and expensive sighs everywhere; "patient representatives" are created, layers of ward clerks are added, et cetera.

Papercare—patient care: A new hospital bureaucracy, as a result of medicare regulations and financing.

And because medicare pays, the most expensive form of acquiring equipment—leasing—becomes the rule. Loans are made by hospitals because medicare will pay the interest—when the hospital has the capital in the first place.

The Federal subsidy has created a new and expensive bureaucracy; and with this bureaucratization, the patient becomes less significant. The PSRO, QAP, and utilization review layers of bureaucracy and the outside layers of review will soon add billions to the cost.

Fallacy No. 5; that if the Federal Government ran medicine, or "restructured" it, costs and efficiency would improve.

First: In the CMS study on the U.S. Public Health Service proposals, a copy of which I am leaving with you today, the costs per stay of all private hospitals in the New Orleans area was lower than for the Federal PHS hospitals. See appendix C, figures 2, 3, and 4.

Second: In addition, an on-site visit disclosed that most of the beds were empty.

Third: On a public hearing PHS physicians testified that they were instructed "to keep our patients so long as possible" (p. 9); helicopters to pick up patients to help fill the hospital; transfer of patients hundreds of miles for insignificant ailments to keep the beds full; instructions to admit patients for routine X-ray studies, et cetera.

Forced overutilization, as a policy, in the Federal hospital. This is politicized hospitals and politicized doctors, with their loyalty to the hospital budget.

Fourth: The cost per stay of Federal hospitals highly exceeds that of private hospitals. [See appendix C, figure No. 1.]

Fallacy No. 6: That Federal program outpatient visits would lower costs and improve access.

First: An HEW study shows that OEO clinic visits and visits to an established Washington HMO are twice as expensive as visits to a private doctor's office [DHEW, HSMHA, CHS, Community Profile Data Center: "The Cost of Standard Medical Services under Alternative Delivery Systems," October 1972].

Second: A visit to the VA outpatient clinic cost $39.50 in 1971 [CMS PHS booklet, p. 20, app. F].

Fallacy No. 7: That HMO's [prepaid contract practice] will contain costs and increase quality and access.

We have heard testimony this morning on that.

The failure of HMO's nationwide in the past few years is now obvious to most. Kaiser-Permanente has had large premium increases every year, has fewer doctors per capita, and see fewer patients as outpatients; 44 percent of subscribers have treatment outside of Kaiser. Also, the limitations on the treatment of postponable surgery, such as hernia, and so on, and their bias against admission of elderly patients weights the scales against early patient care and the whole concept of preventive medicine. [Reference: Kaiser-Permanente Health Plan—Why it works, by Greer Williams, published by the Kaiser Foundation.]

The Connecticut General Brooklyn HMO has failed. This was touted as a great new enterprise. It has failed.

Dozens of HMO's in California have failed, and were viewed as public scandals on their nonperformance. The Johns Hopkins-Connecticut General HMO lost $750,000 in its second year in Columbia; the Harvard Plan had great financial losses; the New Haven HMO accumulated large losses; the UAW HMO-Metropolitan Hospital in Detroit could not get sufficient subscribers from its own union members; the Appalachia experiment of the miners' extensive system of hospitals failed; the I.C. Railroad Hospital, an HMO in New Orleans, has also failed.

I submitted this material in a CMS statement to the Armed Services Subcommittee in 1973, and I have included a copy of that statement for your consideration this morning.

Fallacy No. 8: That U.S. medical care is second rate as evidenced by infant mortality comparisons with other countries.

In this country the reporting of infants' births and deaths is extremely accurate because 97.4 percent of births occur in hospitals. In the Netherlands, rated second, only 30 percent of deliveries are in hospitals, most are by midwives, and there are no rigid requirements for reporting. The criteria for definition of infant mortality varies in different countries, therefore, no real comparison can be made.

Most authorities have now conceded that infant mortality reflects hereditary factors and socioeconomic conditions, not medical care. As a matter of fact, infant mortality in the United States has shown a decrease of 94.5 percent in the 31 years between 1940 and 1971. The CMS statement on infant mortality to the Senate Committee on Finance in 1970 is represented in the attachment to my statement, appendix D.

Second: That many other countries have lower maternal death rates; many have longer life expectancies of men, and that the black are disadvantaged in all these indices, as well as infant mortality.

I think something is going well in this country and I don't say it is necessarily due to medical factors. The socioeconomic advantages have shown a dramatic improvement in the statistics of the nonwhite. From a very bad beginning, they have improved dramatically.

Now fallacy No. 9: There is a doctor shortage of 50,000 doctors.

The "doctor shortage," in quotes, has vanished. The 50,000 doctors claimed needed in 1965 have now graduated. We are now producing doctors three times as fast as the increase in population. The United States has more doctors per population than the majority of the European countries except Austria and Israel.

A doctor glut is now predicted. Too many specialists is now the crisis.

Mr. Chairman, medicine in any event is flexible and responsive. If we needed specialists, we created them. Now we need more family doctors and Congress has acted in that direction. We have a flexible system.

The myopia is that we look at what is now in front of us instead of looking at the total and changing situation. Our system isn't perfect, but it is the best in the world. Now, we need more family doctors. Twenty years ago, we wanted research, and now we have too many dollars in research. The cry of maldistribution in our view is, of course, due to the socioeconomics of the situation. We have a specific suggestion here for the subcommittee. Let's not draft the doctors to serve in the underserved areas. Why not do it the American way, and offer the incentive to the graduating physician of a 3-year exemption from income tax? We will have the doctors there—and the chances are that they will get to love it, because rural America is a beloved part of our country.

Fifth: We believe in the right of the attending physician to prescribe the medication which he thinks best for his patient. That must never be interfered with.

I refer you to our book, "Physicians' Views on Prescription Drugs," on the disastrous effects of generic prescribing. And, we would remind you of these brief statistics: In our view, the use of digitalis in the generic form has resulted in a calculated mortality—this is on page 14—which exceeds the toll of lives in Vietnam.

We also, in studying the national health insurance program—we warn you about drug peer review." The San Joaquin program in California is advocating the same treatment which has caused deaths in Boston. The details are in our book.

On page 14, under paragraph C, we decry the MAC program which is essentially cheap drugs for the poor and aged. I don't believe we have a justification for MAC from its own references. I have provided you with the CMS statement on MAC in the documentation I am leaving with you today.

Sixth: We believe that the existing tax supported Federal programs should be independently audited regularly.

Seventh: On page 15, No. 7, we recognize the problems in the care of the indigent, the disabled, and the unemployed.

Government programs should in our view provide coverage through private health insurance policy for the indigent, with safeguards of free choice of physician of the doctor and his patients.

We do not believe that we should mandate the poor to the welfare clinic bench.

To maintain the loyalty of the doctor to the patient, again, give the money to the patient and let them "peer review" the physician with their choice.

We believe each insurance program still in effect should add an unemployment clause with sufficient premiums to carry it for 1 year.

I will skip section A, and go to section B: 94 percent of the people in the country are covered by insurance. We know there are gaps. We recognize that as practicing physicians. We intend to do better. We believe that the unemployed and the high risk, and the poor, and the dependents of deceased employees, and the high cost of individual policies versus the unavailability of group rates to firms with few employees, these are the areas where we should concentrate our efforts today.

We believe that a nationwide educational program should inform the public and employers that we can voluntarily and inexpensively add catastrophic coverage to the present existing group policies.

It only costs a few dollars a month to cover for a quarter of a million dollars.

The reason for this, and this is No. 8 on page 16, in 20 years' experience of the Federal health employees benefits insurance program, there have only been 16 people whose medical care bill exceeded $50,000.

Therefore, we can cover the population for a $50,000 limit, and 99.9 percent of the population will be protected against catastrophic illness, and the cost of this is a few dollars a year added to a group insurance, because there are so very few people who need the coverage.

That is our recommendations on catastrophic coverage: congressional initiative and leadership to stimulate voluntary coverage, not legislation, and no Federal moneys.

Ninth: Finally, the privacy of communications between physicians and patients must be respected. Invasion of privacy by the bureaucracy in medical records cannot be emphasized enough. This is on page 17.

Medicare agents microfilm the entire medical records of patients; they put a second copy in a bank vault and send the third one to the Federal Records Center.

I do not believe we have in the intent of Congress the desire to microfilm for the Government the details of our patients' private lives found in those records.

You should consider legislation to stop the wholesale invasion of privacy which in our view makes Watergate pale into insignificance.

We have specific recommendations for legislation on the confidentiality of medical records for your consideration. Congressman Phil Crane has recently drafted a bill along these lines which CMS most heartily endorses.

We are leaving with you today a copy of "The Fight for the Patient's Privacy" article by Allan Brownfeld of June 1971, detailing the medicare invasion of privacy.

The CMS resolution on confidentiality is on appendix G, page 26.

Tenth: The Government shall refrain from compulsory universal national health insurance because it is not needed, because it would impose a tremendous tax burden certain to bankrupt the country. Politicalized medicare care must ration medical care to that which the Government can afford, not that which the patient needs.

Eleventh: The excesses of the bureaucracy, through the device of the Federal Register and use of internal manuals have thwarted the intent of Congress and created the true medical crisis; the crisis of overregulation by the bureaucracy. Congressional oversight committees should assure that the law and regulations are controlling, not internal bureau manuals. Examples: We have several monographs documenting the certification fraud by the Medicare Bureau of Health Insurance, summarized on appendix 4, page 27.

Medicare uses internal manuals to change the nature of the law and the regulations.

The utilization review regulations of November 29, 1974, violate the requirements of the Administrative Practice Act, and we have therefore filed suit. More recently we have seen the Bureau of Health Insurance deny hospitals throughout the country their choice to have outside experts review the necessity of hospitalization.

Mr. Chairman, you know that utilization review refers to the necessity for hospital services. We have sponsored an outside expert, an arms-length procedure, not a conflict-of-interest position within the staff.

We have found that in your wisdom Congress provided for an "option 3" for such outside experts to perform utilization review. Hundreds of hospitals have now requested this option 3. Mr. Tierney, head of the Medicare Bureau, cites a ruling in his "private manual," and pronounces option 3 as "not available." We request that the Ways and Means Committee instruct the Bureau that option 3 be available.

In summary, Mr. Chairman, Congress should consider an overall national health policy and the following recommendations:

One: The American quality system of individuality, dignity, and privacy in medical care is based on the private patient-physician contract. This contract must be preserved inviolable. This can be accomplished only by the establishment of direct billing of the patient in all Federal health programs.

Two: Rationing of medical care, the Federal rulebook for the treatment of all diseases, and the invasion of privacy should be rejected; the radical PSRO law should be repealed. Imposition of PSRO by utilization review procedures should be eliminated.

Three: Interference by the bureaucracy in patient care must be prohibited as evidenced in the recent ruling by the Bureau of Health Insurance to deny payment for general anesthesia and for the use of surgical assistants during cataract surgery. This ruling effectively denies to the patient the benefits of advancements in medical care.

Four: There is no health crisis. There are gaps in care which reflect the unsolved social problem of poverty in all civilizations.

Five: The increasing cost of hospitalization, over that due to the decreasing value of the dollar, is due to the Federal and private insurance financing's blank check which makes hospital services appear free to the patient. We urge that deductibles, coinsurance and copayments be maintained for all programs. These control mechanisms provided by laws passed by Congress are made ineffective by the offering of insurance policies to cover deductible and coinsurance.

Six: Eliminate first-dollar coverage in all programs. The high cost of claims review will double the cost of small claims, such as prescription drugs.

Seven: An independent congressional task force should study the

Veterans and Public Health Service hospitals to ascertain costs, length of stay, adequacy of care, and patient satisfaction.

Eight: Subsidy should not be provided for any special medical care system, because with subsidy, one cannot evaluate their services, nor the cost of services. Let the patients decide which systems they prefer.

Nine: To stimulate doctors to practice in underserved areas, we recommend an exemption from income tax for 3 years.

Ten: Substitution for drugs or treatment by anyone other than the attending physician must be prohibited, with penalties, in all Federal programs. CMS estimates that more lives have been lost from the use of Government-sponsored generic drugs—digitalis—than were lost in the Vietnam War.

Eleven: The MAC program of cheap drugs for the aged and the poor must be suspended by Congress. This cruel hoax imposed on patients based on scant data and illustory savings must be eliminated.

Twelve: Peer review drug programs have not saved money nor improved quality and should not be incorporated in Federal health programs.

Thirteen: Regular GAO and independent congressional audits should be made of federally subsidized HMO's, foundations, family health corporations, et cetera, for cost and performance.

Fourteen: Fill the gaps in health care coverage. Here, CMS recommends:

One: For the unemployed, the voluntary addition to existing policies of unemployment coverage through payment of an appropriate premium, to cover 1 year of unemployment.

Two: For the high-risk citizen who cannot buy insurance, legislation to require insurance pools, to provide coverage at group policy rates.

Three: For employees of small firms, State legislation to allow pooling of small-firm employees to provide group-policy rates should precede consideration of any Federal action.

Four: For the indigent, medicaid should be eliminated. Insurance should be provided to the indigent with a direct billing option and free choice of doctor and hospital. This will bring the poor back into the mainstream of dignity and quality medical care of their choice, not second-class citizenship at the clinic bench. This will be an expensive program, but necessary as an act of social justice. Some of the funding will be provided from the next recommendation.

Five: Deductibles should be preserved, even for the poor, on a sliding scale.

Six: For those able to pay for their medical care, Congress should repeal any benefits under medicare. There is no justification to subsidize with tax dollars those who are not in need, while denying the poor from care.

Seven: For catastrophic illness, coverage for catastrophic illness is inexpensive and currently available. CMS, therefore, recomends a congressional initiative to the people. A task force could encourage nationwide voluntary addition of catastrophic coverage to existing policies. CMS is ready to cooperate and assist you at the grassroots level.

Thank you, Mr. Chairman.

[Full text of Dr. Oller's statement follows:]

STATEMENT OF JOSÉ L. GARCÍA OLLER, M.D., PRESIDENT, AMERICAN COUNCIL OF MEDICAL STAFFS

CONCLUSIONS

1. Personal, individualized care of high quality, with dignity and privacy, at a cost to the citizen on the basis of a patient-physcian agreement is the hallmark of the American system of Private Medicine. Its continued and expanded availability under free enterprise is the proper goal of our National policy on Medical Care.

2. The citizen's *right to choose his private doctor*, to receive medical care in accordance with his physician's best judgment, and the physician's right to administer it, must not be limited.

3. These decisions are inherent in the practice of medicine: the care, diagnosis and theatment and the admission and discharge of patients from hospitals and facilities. They are to remain the prerogative of the patient's attending physician, not of government or insurance companies.

There shall not be Federal intervention in the private practice of medicine such as: control of admissions by government committees; treatment of the sick dictated thru government approved manuals (PSRO); length of stays in a hospital imposed by computerized averages; and denials of "necessity of hospitalization" determined by government carriers who have never examined the patient.

4. The concept of "Health Crisis" was based on fallacious assumptions, upon which "Crisis Health Legislation" was enacted in the '60's. Such government intervention has led to additional inflation of costs, and the *rationing* of medical services in Medicare and Medicaid. *Proposed increased intervention* in *medical care will lead to additional inflation* of costs and increased *rationing* of services, and will *aggravate, not reduce,* problems of access to doctors, and maldistribution of hospital beds or of physicians. Evaluation of proposals for medical care should always include significant input from practicing doctors.

5. The right of the attending physician to prescribe the medication which he deems best for the individual patient, considering the uniqueness of both patients and disease, is essential for quality medical care. Compulsory *limitation of choice in prescribing*, or compulsory *substitution* of other drugs, should be prohibited.

6. Existing tax-supported federal programs including HMO's and "Foundations" should be regularly evaluated by independent audits of performance, costs and efficiency and actual delivery of services. Proposed programs should first be tested in prototype, again with independent audits of performance, before expensive national programs are implemented at the taxpayer's expense. Programs that fail in performance should be eliminated from public subsidy, and the legislation repealed.

7. We recognize the problems in the care of the indigent, the disabled and the unemployed. Should the government make available *private health insurance for the indigent*, it must safeguard free choice of physician and hospital. To maintain the loyalty of the doctor to his patients, the option of payment to the patient must be preserved ("direct billing"). Continuation of *insurance coverage during disability and unemployment* should be provided by the addition of appropriate clauses to current *voluntary insurance programs.*

8. A nationwide educational program shall inform the public and employers that the addition of "*catastrophic coverage*" to their present health policies is available and *inexpensive.* The public should be thus encouraged to buy this additional protection. There is *no need for compulsory "catastrophic"* insurance.

9. All Federal programs shall respect that the communication between physicians and patients *must remain confidential,* recognizing that the free exchange of information is essential to proper treatment. Legislation should assure that only information necessary to establish claims from illness, but *not information about patients' personal lives* shall be subject to review by the government or insurance carriers.

10. The government shall refrain from *compulsory universal* national health insurance: because it is not needed, because government should not pay for that which a citizen can afford, because it would impose a tremendous tax burden certain to bankrupt the country. *Politicalized medical care must* ration medical care to that which the government can afford, not that which the patient needs.

11. The excesses of the Bureaucracy, through the device of the FEDERAL REGISTER and use of "Internal Manuals", have thwarted the intent of Con-

gress and created the true Medical Crisis: the crisis of overregulation in the Bureaucracy. Congressional oversight committees should assure that the Law and Regulations are controlling, not Internal Bureau manuals.

RECOMMENDATIONS

1. A "National Health Policy" to set goals and principles is offered to Congress.

2. The American quality system of individuality, dignity and privacy in medical care is based on the private patient-physician contract. This contract must be preserved inviolable. This can be accomplished only by the establishment of *direct-billing* of the patient in *all* federal health programs.

3. Rationing of medical care, the federal rulebook for the treatment of all diseases and the invasion of privacy should be rejected: the radical PSRO law should be repealed. Imposition of PSRO by Utilization Review procedures should be eliminated.

4. Interference by the Bureaucracy in patient care must be prohibited as evidenced in the recent ruling by the Bureau of Health Insurance to deny payment for general anesthesia and for the use of surgical assistant during cataract surgery. This ruling effectively denies to the patient the benefits of advancements in medical care.

5. There is no Health Crisis. There are "gaps" in care which reflect the unsolved social problem of "poverty" in all civilizations.

6. The increasing cost of hospitalization, over that due to the decreasing value of the dollar, is due to the federal and private insurance financing's "blank check" which makes hospital services appear "free" to the patient. We urge that deductibles, co-insurance and co-payments be maintained for *all programs.* These control mechanisms provided by laws passed by Congress are made ineffective by the offering of insurance policies to cover deductibles and co-insurance.

7. Eliminate first dollar coverage in all programs. The high cost of claims review will double the cost of small claims, such as prescription drugs.

8. An independent Congressional Task Force should study the Veterans and Public Service hospitals to ascertain costs, length of stay, adequacy of care, and patient satisfaction.

9. Subsidy should not be provided for any special medical care "system", because with subsidy, one cannot evaluate their services, nor the cost of services. Let the patients decide which "systems" they prefer.

10. To stimulate doctors to practice in underserved areas, we recommend an exemption from income tax for 3 years.

11. Substitution of drugs or treatment by anyone other than the attending physician must be prohibited, with penalties, in all federal programs. CMS estimates that more lives have been lost from the use of government-sponsored generic drugs (digitalis) than were lost in the Viet Nam War.

12. The "MAC" program of cheap drugs for the aged and the poor must be suspended by Congress. This cruel hoax imposed on patients based on scant data and illusory savings, must be eliminated.

13. "Peer Review Drug Programs" have not saved money nor improved quality, and should not be incorporated in federal health programs.

14. Regular GAO and independent Congressional audits should be made of federally subsidized HMOs, Foundations, Family Health Corporations, etc. for cost and performance.

15. For the "gaps" in health care coverage, CMS recommends:

(1) *For the unemployed:* The *voluntary* addition to existing policies of "unemployment coverage" through payment of an appropriate premium, to cover 1 year of unemployment.

(2) *For the high-risk citizen who cannot buy insurance:* Legislation to require insurance pools, to provide coverage at group-policy rates.

(3) *For employees of small firms:* State legislation to allow pooling of small-firm employees to provide group-policy rates should precede consideration of any federal action.

(4) *For the indigent:* Medicaid should be eliminated. *Insurance* should be provided to the indigent *with a direct-billing* option and free choice of doctor and hospital. This will bring the poor back into the mainstream of dignity and quality medical care of their choice, not second-class citizenship at the clinic bench. This will be an expensive program, but necessary as an act of social justice. Some of the funding will be provided from the next Recommendation.

(5) Deductibles should be preserved, even for the poor, on a sliding scale.

(6) *For those able to pay for their medical care:* Congress should repeal any benefits under Medicare. There is no justification to subsidize with tax dollars those who are not in need; while denying the poor from care.

(7) *For "Catastrophic Illness":* Coverage for catastrophic illness is inexpensive and currently available. (We do not need "legislation" for catastrophic illness.) CMS, therefore, recommends a Congressional initiative to the people: a Task Force to encourage nationwide voluntary addition of *catastrophic* coverage to existing policies. CMS is ready to cooperate and assist you at the grassroots level.

I. INTRODUCTION

Mr. Chairman, Members of the Subcommtitee, I am Dr. José L. García Oller, President and Founder of American CMS—the American Council of Medical Staffs. I have limited my private practice to the field of brain surgery for the past 25 years, and for 15 years served the indigent as Head of the Independent Neurosurgery Unit at Charity Hospital in New Orleans. I am a graduate of the Jefferson Medical College in Pennsylvania, class of 1945. With me is Edward S. Hyman, M.D., Secretary of American CMS. A 1946 graduate of The Johns Hopkins Medical School, he is a privately practicing specialist in Internal Medicine for 22 years, and a research biophysicist.

A. CMS Founded in 1968.

CMS was founded in 1968 as a unique grassroots organization designed to obtain the votes of private doctors. This was achieved by organizing through the existing medical staffs of community hospitals (non-profit or for-profit). Because attendance is required at staff meetings, we can obtain consensus through regular votes on issues.

B. CMS the Largest Organization of Private Doctors

American CMS is now the second largest medical organization in the United States, and the largest organization representing only private doctors. Our voting membership is 38,851, comprising 63 Chapters and 29 States, and growing by the addition of a new medical staff about every 2 weeks. A list of the National Board of Directors of American CMS is in Appendix A.

C. CMS Represtnts the Needs of Patients.

It is necessary that public policy in the field of health care be responsive to the needs of the patient. This is why we are here: to present the needs of the American patient by those most qualified to define that need, those actually delivering medical care on a day-to-day basis—the private doctors of America.

CMS holds that private medical care of the American citizen is a highly specialized area, a combination of art and science, requiring intensive day-to-day experience with large numbers of flesh-and-bone sick people. Then, and only then, is a doctor qualified to speak for the sick. Full-time academicians, professors, researchers, educators, and a number of medical economists, who do not have the workday responsibility for the actual care of the sick, are not competent to represent them.

CMS is grateful to the Subcommittee for this opportunity to present to you our recommendations for a National Health Policy.

II. A NATIONAL HEALTH POLICY

1. Personal, individualized care of high quality, with dignity and privacy, at a cost to the citizen on the basis of a patient-physician agreement is the hallmark of the American system of Private Medicine. Its continued and expended availability under free enterprise is the proper goal of our National policy on Medical Care.

2. The citizen's right to choose his private doctor, to receive medical care in accordance with his physician's best judgment, and the physician's right to administer it, must not be limited.

3. These decisions are inherent in the practice of medicine: the care, diagnosis and treatment and the admission and discharge of patients from hospitals and facilities. They are to remain the prerogative of the patient's attending physician, not of government or insurance companies.

There shall be no Federal intervention in the private practice of medicine such as: control of admissions by government committees; treatment of the sick dictated thru government approved manuals; length of stays in a hospital imposed by computerized averages; and denials of "necessity of hospitalization" determined by government carriers who have never examined the patient.

A. PSRO—Rationing of Medical Care.

PSRO, "sold" as a "cost-control" mechanism for national health insurance by the Nixon administration, is in fact a full-scale rationing system which does violence to the principles of the patient's right to privacy and choice of treatment and the physician's right to individualized judgment.

B. Invasion of Privacy.

Called by the Wall Street Journal as "The most radical legislation in this country's history", PSRO can be summarized in its own terms:

It is a law whose functions can be summarized as those of three committees:

Committtee No. 1—Invasion of Privacy: PSRO authorizes the examinaion of private medical records in private doctors' offices.

Sec. 1155(b)(3): "(3) examine patient records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under subsection (a)(1)

"(4) inspect the facilities in which care is rendered or services provided (which are located in such area) of any practitioner or provider."

Committee No. 2—Rationing of Hospital Admissions—Prior to Admission.

Sec. 1155(a)(2): "(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

"(A) any elective admission to a hospital, or other health care facility, or"

Committee No. 3—A Federal Rulebook for the Diagnosis, Care and Treatment of all Disease.

"Sec. 1156(a) Each Professional Standards Review Organization shall apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice in its regions (including typical lengths-of-stay for institutional care by age and diagnosis—as principal points of evaluation and review."

C. The Common Cold treated by PSRO-type Guidelines.

A simple and clear example on how PSRO work is provided by the PSRO prototype, San Joaquin Foundation for Medical Care, in its testimony before the Senate Finance Committee, in 1970, Pages 782–784. As shown on the CMS Book entitled "PSRO", a copy of which I am leaving with you, today, May 1973, Page 29, Exhibit 3, the Guidelines for the Treatment of the first example given, the Common Cold, are as follows:

Diagnosis:

Acute upper respiratory infection in the absence of a complicating factor.

Visits:

Either home or office, preferably office.

Numbber of visits:

Between 2 and 4, or 1 and a phone call.

Frequency of visits:

Three to four days apart.

Lab & X-Ray:

Seldom. X-ray of chest when complications are present. WBC and differential may be indicated. Culture may be indicated.

Therapy:

Analagesics, sedatives, antitussives, expectorants, anti-histamines, and chemotherapy.

Duration:

Seven to ten days.

The cost following these guidelines are as follows:

A. PSRO Cold

Office visit	$7.00
Drugs—one cold	7.00
WBC	7.00
Culture and sensitivity	20.00
Total	41.00

B. Cost for U.S. Population:

For 200 million population, 4 colds per year at $41.00 per cold,, plus one X-ray of chest out of 10 colds at $15=$34 Billion.

Comment: The cost of all doctors' services in the United States approximates 21 billion dollars a year.

D. CMS Suit on PSRO

CMS refers you for a detailed analysis of the threat of PSRO to the health of the people to our Senate Committee on Finance Testimony, May 9, 1974, and our Amicus Curiae brief, published as "PSRO II, The Case for Repeal," a copy of which I am also leaving with each of you.

E. Medicare Ruling on Anesthesia and Surgery

To illustrate the excesses of the Federal bureaucracy (Mr. T. Tierney, Director, Medicare Bureau of Health Insurance) in determination of "medical necessity," witness the unconscionable ruling just issued: Medicare insurance companies "will determine the reasonableness and necessity" of a general anesthetic for cataract surgery, and "of an assistant surgeon in cataract surgery" (see Appendix B).

The physician throughout history has been the protector of his patient's health from a potential tyranny. To suffer a ruling from a bureaucrat to tamper with the risk of survival in the operating room by withdrawing payment for anesthetics and surgical assistants is to give HEW the power over life and death.

F. Recommendations

1. PSRO (Public Law 92–603, Section 249F) should be repealed.

2. Benefits under federal programs should be uniform throughout the country.

3. The infamous recent ruling by the Medicare Bureau to make determinations on the necessity or reasonableness of anesthetic and surgeon's assistant must be overruled. The Social Security Act already prohibits such intervention. Section 1801 of the Social Security Act reads:

"Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure or compensation of any . . . person providing health services, or to exercise any supervision or control over . . . such . . . person"

4 The concept of "Health Crisis" was based on fallacious assumptions, upon which "Crisis Health Legislation" was enacted in the '60's. Such government intervention has led to additional inflation of costs, and the rationing of medical services in Medicare and Medicaid. Proposed increased intervention in medical care will lead to additional inflation of costs and increased rationing of services, and will aggravate, not reduce, problems of access to doctors, and maldistribution of hospital beds or of physicians. Evaluation of proposals for medical care should always include significant input from practicing doctors.

A sober evaluation of the arguments of the "Health Crisis" finds them fallacious, to wit:

Fallacy No. 1

"Medical Care Costs and Physician Fees have risen twice as fast as the Consumer Price Index."

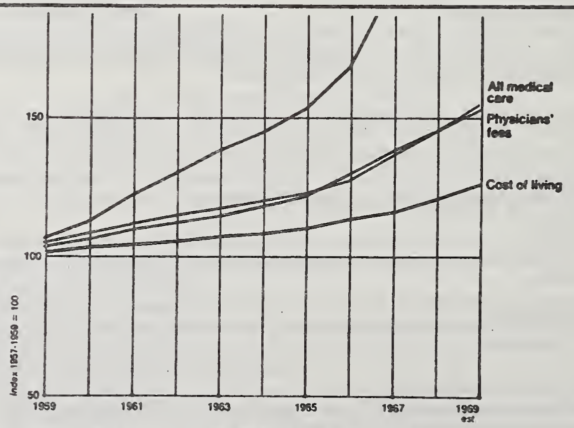
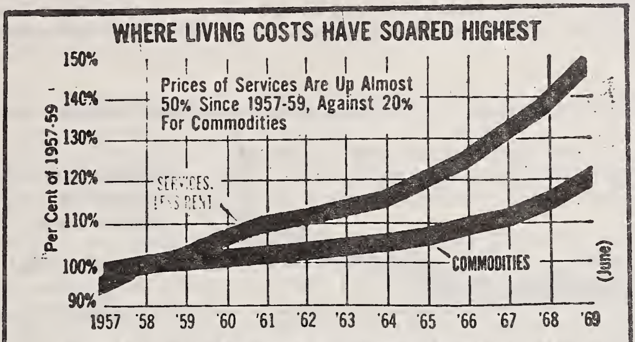


Figure 1 Fortune Magazine, January, 1970

This comparison is improper because it compares services to commodities. Medical care is a service, and should be compared with the C.P.I. for services. When this is done, as in Figure 2, the C.P.I. for "services" (less rent) is identical in rise to that of medical care.



Source: Bureau of Labor Statistics, CPI. Copyright 1969, U.S. News & World Report, Inc.

Figure 2 Consumer Price Index

Fallacy No. 2

"Physicians' fees are spiraling above the economy."

When physicians' fees were compared over a 13 year period, before and after Medicare, they were seen to be almost identical to the rise of wages in covered employment. (Fig. 3).

TABLE 10-5.—COMPARISON OF ANNUAL INCREASES IN PHYSICIAN FEES AND IN WAGES

[In percent]

Calendar year [1]	Physician fees [2]	Average wages in covered employment	Differential increase of physician fees
1956	3.1	5.7	−2.6
1957	4.4	5.5	−1.1
1958	3.4	3.3	.1
1959	3.9	3.3	.6
1960	1.8	4.3	−2.5
1961	2.6	3.1	−.5
1962	3.1	4.2	−.9
1963	2.2	2.4	−.2
1964	2.3	3.1	−.8
1965	3.3	1.6	1.7
Average, 1956–65	3.0	3.6	−.6
1966	5.9	4.4	1.5
1967	7.3	6.3	1.0
1968	5.5	7.0	−1.5
Average, 1956–68	3.7	4.2	.5

[1] Increase from June of previous year to June of year listed for 1st column and from 1st quarter of previous year to 1st quarter of year listed for last column.

[2] As measured by Consumer Price Index of physician fees.

Since the period of Wage and Price Control, medical care costs have risen on a par with services in general.

Fallacy No. 3

"Prescription Drugs prices are escalating".

Prescription Drugs have, since 1960 and to the present, remained below the general C.P.I. level. (Fig. 4)

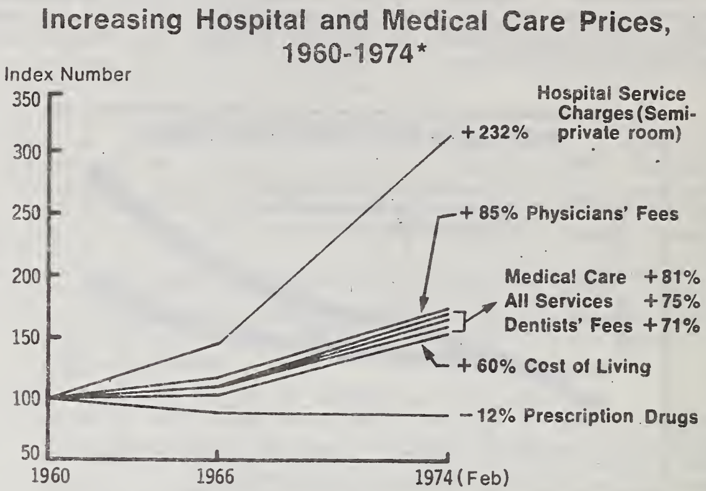


Figure 4 Chamber of Commerce, "Comparative Analysis of Major National Health Insurance Proposals," April 1974

There is thus no support for Senator Kennedy's opening statement during his "Health Care Crisis" Hearing in 1971: "Each of us know that doctor bills, hospital bills, the cost of drugs, nursing home care and the like are out of control"—except for hospital costs.

Fallacy No. 4

"The Runaway Cost of Hospital Care implies a failure of the private Hospital "non-system"—and what we need is a federally regulated system".

1. "Most now have come to recognize that in a wage-intensive industry, the upgrading of previously depressed wages of the hospital worker has had a significant impact, following the escalating "minimum wage" laws.

2. We also recognize the dramatic technological progress requiring expensive equipment and specialized care units.

3. The rising cost of hospitalization is related to the "blank check" of insurance coverage, and, in the case of private carriers, the bias in favor of hospitalization, as against non-covered office care. The sharp rise in the curve since Medicare, however, shows that government financing has *compounded* the problem many fold.

4. As so well stated by Prof. M. Feldstein before these hearings on July 24, to the patients with insurance coverage paying 77% of the cost, the increase of per diem cost from $16 in 1950 to the $125 cost in 1970 actually appears *to the patient* as a rise of only $3.

5. If we are to moderate hospital cost escalation in federal (and other) "insurance" programs, we *must eliminate first* dollar coverage. Insurance carriers should not vitiate the effectiveness of deductibles by offering insurance to cover them. The high cost of claims review for small bills amounts to double payment. For example; if the average cost of a prescription is $4.50, and its *review* also costs $4.50.

6. The Medicare program is rapidly becoming a *Papercare* program, with the preoccupation for the care and feeding of the forms and the computers to satisfy government rules; entire new departments have arisen in hospitals; there are more people in the business office than in laboratories; personnel proliferates with a massive featherbedding of questionably useful personnel and activities which are paid for by Medicare.

With the promise of Medicare reimbursements, public relations departments have sprung like an epidemic; parking lots proliferate; beautiful and expensive signs everywhere, "patient representatives" are created, layers of ward clerks are added, etc.

Papercare—not patient care. A new hospital bureaucracy, as a result of Medicare regulations and financing.

And because Medicare pays, the most expensive form of acquiring equipment—leasing—becomes the rule. Loans are made by hospitals because Medicare will pay the interest—when the hospital has the capital in the first place.

The federal subsidy has created a new and expensive bureaucracy: and with this bureaucratization, the *patient* becomes less significant. The PSRO, QAP, and Utilization Review layers of bureaucracy and the outside layers of review will soon add billions to the cost.

Fallacy No. 5

"That if the Federal government ran medicine, or "restructured it", costs and efficiency would improve."

1. In the CMS study on the "U.S. Public Health Service Proposals", a copy of which I am leaving with you today, the costs *per stay* of all private hospitals in the New Orleans area was lower than for the federal P.H.S. hospitals. (See Appendix C, Fig. 2, 3, 4)

2. In addition, an on-site visit disclosed that most of the beds were empty.

3. On a public hearing, P.H.S. physicians testified that they were instructed "to keep our patients so long as possible" (p. 9); helicopters to pick up patients to help fill the hospital; transfer of patients hundreds of miles for insignificant ailments to keep the beds full; instructions to admit patients for routine X-ray sudies, etc. Forced overutilization, *as a policy*, in the Federal hospital. This is *politicized hospitals* and *politicized doctors*, with their loyalty to the hospital budget.

4. The cost per stay of Federal hospitals highly exceeds that of private hospitals. (See Appendix C, Figure 1)

Fallacy No. 6

"That Federal program 'outpatient' visits would lower costs and improve access."

1. An HEW study shows that OEO clinic visits and visits to an established Washington HMO are *twice as expensive* as visits to a private doctor's office: (DHEW, HSMHA, CHS, Community Profile Data Center: "The Cost of Standard Medical Services under Alternative Delivery Systems", October 1972).

2. A visit to the VA outpatient clinic cost $39.50 in 1971. (CMS P.H.S. booklet, p. 20, Appendix F).

Fallacy No. 7

"That HMO's (prepaid contract practice) will contain costs and increase quality and access."

The failure of HMO's nationwide in the past few years is now obvious to most. Kaiser-Permanente has had large premium increases every year, has fewer doctors per capita and *see fewer* patients as outpatients; 44% of subscribers have treatment outside of Kaiser. Also, the limitations on the treatment of postponable surgery (hernia, etc.), and their bias against admission of elderly patients weighs the scales against early patient care and the whole concept of "preventive medicine". (Reference: Kaiser-Permanente Health Plan—Why it works by Greer Williams, published by the Kaiser Foundation)

The Connecticut General Brooklyn HMO has failed. Dozens of HMO's in California have failed, and were viewed as public scandals on their non-performance. The John Hopkins-Connecticut General HMO lost $750,000 in its second year in Columbia; the Harvard Plan had great financial losses; the New Haven HMO accumulated large losses; the UAW HMO-Metropolitan Hospital in Detroit could not get sufficient subscribers from its own union members; the Appalachia experiment of the Miners' extensive system of hospitals failed; the I.C. Railroad Hospital (HMO) in New Orleans has also failed.

Dr. Sidney Garfield, founder of Kaiser-Permanente, stated:

> Elimination of the fee has always been a must in our thinking, since it is a barrier to early entry into sick care. Early entry is essential for early treatment and for preventing serious illness and complications. Only after years of costly experience did we discover that the elimination of the fee is practically as much of a barrier to early sick care as the fee itself. The reason is that when we removed the fee, we removed the regulator of flow into the system and put nothing in its place. The result is an uncontrolled flood of well, worried-well, early-sick and sick people into our point of entry—the doctor's appointment—on a first come, first served basis that has

> little relation to priority of need. The impact of this demand overloads the system, and, since the well and worried-well people are a considerable proportion of our entry mix, the usurping of available doctors' time by the healthy people actually interferes with the care of the sick. (Reference: Scientific American, 1970.)

I am providing for you a copy of the CMS statement on HMO's to the Armed Services Subcommittee on September 1973 for your consideration.

Fallacy No. 8

1. "That U.S. Medical Care is second rate as evidenced by infant mortality comparison with other countries."

> In this country the reporting of infant births and deaths is extremely accurate because 97.4% of births occur in hospitals. In the Netherlands (rated second) only 30% of deliveries are in hospitals, most are by midwives and there are no rigid requirements for reporting. The criteria for definition of infant mortality varies in different countries, therefore, no real comparison can be made.

Most authorities have now conceded that infant mortality reflects hereditary factors and socioeconomic conditions, not "medical care". As a matter of fact, infant mortality in the United States has shown a decrease of 94.5% in the 31 years between 1940–71. The CMS statement on infant mortality to the Senate Committee on Finance in 1970 is reproduced in Appendix "D".

2. "That many other countries have lower maternal *death* rates; many have longer life expectancies of men, and that the black are disadvantaged in all these indices, as well as infant mortality."

The genetic and socioeconomic factors led to an initial high disparity of America's genetic melting pot. The critical question is, are we *improving* from this base, and how well? The studies show that the *non-white* has kept pace with improvement in the indices, sometimes faster than the white. Compare the slope of the curves in Appendix E (taken from the "National Health Insurance Resource Book" of this Committee, August 11, 1974.) For expectation of life, see Appendix F, Figure "A"; for white and non-white maternal death rates, see Appendix F, Figure "B", both taken from HEW's "White Paper" (May, 1971, pages 61 and 65).

Fallacy No. 9

"There is a Doctor Shortage of 50,000 doctors."

The "Doctor Shortage" has vanished. The 50,000 doctors claimed needed in 1965, have now graduated. We are now producing doctors *three times as fast* as the increase in population. The U.S. has more doctors per population than the majority of the large countries in the world.

A doctor "glut" is now predicted. "*Too many specialists*" is now the "crisis." Soon, with the massive infusion of dollars towards family practice, the pendulum will swing. The fact is that our medical system is vastly dynamic and adaptable to progress and to the changing requirements of the state of the art.

The cry of "maldistribution" is of course, due to socioeconomics. To stimulate doctors in underserved areas, CMS suggests an income tax exemption for those who choose to practice in those areas—not a Doctor-Draft!

5. The right of the attending physician to prescribe the medication which he deems best for the individual patient, considering the uniqueness of both patients and their disease, is essential for quality medical care. Compulsory *limitation of choice in prescribing*, or compulsory *substitution* of other drugs should be prohibited.

(A) Some disastrous effects of Generic Prescribing were the result of the invalid and discredited theory of the "equivalence" of "Generic" drugs to brand name drugs. In extensive studies, generic drugs have shown dangerous variation in the true bio-availability, and dangerous variation in absorption levels, even from the same production batch! The citizen must know that generic drugs have failed to produce the desired clinical effects and blood levels in such conditions as epilepsy (Dilantin), diabetes (Tolbutamide), in antibiotics (Chloromycetin, Sulfisoxazole, Terramycin), arthritis (Phenylbutazone), thyroid hormone and Cortisone and Prednisone preparations, and anticoagulants (Dicoumarol). Finally, the Digitalis preparation *Digoxin*, used for heart disease, resulted in a calculated mortality due to the use of generic digitalis (as opposed to brand drugs which were reliable) exceeding the toll of lives in Vietnam! The F.D.A. has recently stated that the cost of clinical evaluation, if added to the cost of generics, would about equal the cost of the brand name drug. Who will be responsible for the loss of lives from "compulsory" generics?

(B) CMS has published a book, written by Dr. Edward Hyman as main author, "The Physician's Views on Prescription Drugs," a copy of which I will leave with you today, and urge you to read as an in-depth study of the drug equivalence and drug reaction problem.

The CMS book discusses the fallacy of "drug peer review" programs: e.g., a procedure causing drug reactions in Boston is advocated as a treatment by the San Joaquin Foundation Drug Program.

(C) In our Statement to HEW on the MAC Program (Maximum Allowable Cost of Drugs) Feb. 10, 1975—I submit to you a copy herewith, we observed that MAC is based on: (1) Misrepresentation of Cost Savings; and (2) Misrepresentation of Quality Assurance. MAC will adversely affect research and development of new drugs. MAC will result in serious damage to our patients, and represents a serious interference with the physician's right to prescribe, and the patient's right to receive the treatment given by his chosen doctor.

6. Existing tax-supported federal programs including HMO's and "Foundations" should be regularly evaluated by independent audits of performance, costs and efficiency and actual delivery of services. Proposed programs should first be tested in prototype, again with independent audits of performance, before expensive national programs are implemented at the taxpayers' expense. Programs that fail in performance should be eliminated from public subsidy, and the legislation repealed.

7. We recognize the problems in the care of the indigent, the disabled and the unemployed. Government programs should provide coverage through *private health insurance* policies for the indigent with safeguard of free choice of physician and hospital, instead of mandated "welfare clinic" care. To maintain the loyalty of the doctor to his patients, the patient should have the option to pay the bill through "direct billing"; as in Medicare. Continuation of insurance coverage during disability and unemployment should be provided by the addition of appropriate clauses to current *voluntary* private insurance programs.

(A) To recapitulate the "dollar picture" so well summarized by Professor Lewis Butler before you on July 11, paraphrased:

> *The "industry"*.—Ours is a $120 billion medical care system, representing 8% of GNP, as the second or third largest industry, rising at an inflation 1975 rate of 12%.
>
> *Government Sector.*—Government pays 40% of the total; the Federal government 27% share, 40% of the Medical costs is for hospital care. The 42-plus billion government investment is divided as $15 billion for 23 million Medicare beneficiaries, $14 billion in Medicaid, half-state, half-Federal), for 25 million people; Veterans and Public Health some $8 billion, Biomedical research $2.5 billion, construction $1 billion, Regulation and Control 0.6 billion, Training and Manpower $1 billion.
>
> *Private Sector.*—Mr. Cathles, Aetna Life and Casualty ex-Vice President, reminded us in July that "94% of the under-65 population is covered by private insurance."

(B) But there are gaps: (1) the unemployed and the part-time employed, (2) the high risks, (3) the poor, (4) dependents of deceased employees, (5) the high cost of individual policies vs the unavailability of group rates to firms with few employees.

8. A nationwide education program should inform the public and employers that the addition of "catastrophic coverage" to their present health policies is available and inexpensive. The public should be thus encouraged to buy this additional protection. There is no need for compulsory "catastrophic" insurance; 52.6% of the population was covered under major medical policies as of 1972 (National Health Insurance Resource Book, 1974, page 234, Table 11).

It is thus apparent that population coverage by major medical policies will soon be accomplished on a *voluntary* basis, except for the indigent.

In 1971, HEW stated before the Labor subcommittee Hearings (Feb. 1971 page 50), that in a full 20 years of the Federal employee insurance program, only 16 people had ever exceeded the $50,000 limit of coverage. Thus a $50,000 limit would have then covered more than 99.9% of the population of the country.

Therefore, catastrophic coverage is inexpensive because few losses reach those limits.

9. All Federal programs shall respect the communications between physicians and patients as confidential. Congress recognizes that the free exchange of in-

formation is essential to proper treatment. Legislation should assure that only information necessary to establish claims from illness, but not information about patients' personal lives shall be subject to review by the government or insurance carriers.

Mr. Chairman, nothing is more sacred and more vital to our profession than the confidentiality of our patient's privacy.

Quality medical care can simply not exist without it, because the patient will not then provide his physician with the intimate, personal information he must have to diagnose and treat his properly.

The Medicare Bureau of Health Insurance has made a shambles of confidentiality: they are demanding and obtaining under threat of fiscal blackmail to hospitals, *entire* medical records of Medicare and Medicaid patients. They make up to three microfilm copies. One is kept, for example, in the Louisiana Blue Cross office, the second one in a bank vault; the third one goes to the Federal Record Center in Dallas, Texas.

We see no excuse for the patient's history, physical examination and progress notes to be available to government clerks.

Medicare should have only the face sheet of the chart, with basic identification only, the diagnosis and treatment as recorded by the doctor. Any additional information should be justified and requested from the attending doctor.

The details of one episode wherein CMS challenged this rape of record is contained in the article, The Fight for the Patient's Privacy (Private Practice, June 1971). I am leaving a copy of this article for you. Note on page 3 the Blue Cross letter demanding the entire record as upheld by the Bureau of Health Insurance. We appealed to the late Sen. Ellender in the ensuing conference, with Mr. Tierney, Head of Medicare, he simply stated that he had the power under the law to demand the entire record, and he would.

We strongly urge this Committee to pass legislation to stop this wholesale invasion of privacy which makes Watergate pale into insignificance.

On Appendix G we reprint the CMS Resolution on Confidentiality, "Concerning the Release of Medical Information", which was also approved by the Louisiana State Medical Society. We believe this resolution could be the basis of appropriate legislation. Congressman Crane has already drafted a Bill, which we most heartily endorse.

10. The government shall refrain from compulsory universal national health insurance: because it is not needed, because it would impose a tremendous tax burden certain to bankrupt the country. Politicalized medical care must ration medical care to that which the government can afford, not that which the patient needs.

11. The excesses of the Bureaucracy, through the device of the FEDERAL REGISTER and use of "Internal Manuals", have thwarted the intent of Congress and created the true Medical Crisis: the crisis of overregulation in the Bureaucracy. Congressional oversight committees should assure that the law and Regulations are controlling, not internal Bureau manuals.

Item No. 1.—In Appendix H is a summary of the Certification fraud by the Medicare Department, a classic demonstration of the arrogance of the Bureaucracy, upheld by HIBAC.

Item No. 2.—Invasion of Privacy: demands by the Medicare Department of the entire medical record, and microfilming. (Vide supra.)

Item No. 3.—Use of "Internal Manuals" (Health Insurance Manuals) by Medicare to illegally require the *attending* physician to fill our "Certification" forms, which is not required in the law or the regulations.

Item No. 4.—Utilization Review Regulations of November 29: A gross abuse of the Administrative Practices Act. CMS filed suit on February 5 (two weeks before the AMA); our suit is still in Court to test the abuse of the APA by the Bureau. I leave with you a copy of our suit on Utilization Review.

Item No. 5.—Denial by the Bureau of Utilization Review to hospitals, through the use of "Internal Manuals", of their choice of Utilization Review. CMS has recommended that, if Utilization Review is required for Medicare services of a hospital, it should be done by competent outside experts who do not have a conflict of interest in treating patients with their colleagues of the medical staff. Option iii of the Regulations (CFR 405.1035) provides for such outside review. CMS believes the chart must not leave the hospital and decisions of the reviewer should be final, after consultation is offered to the attending physician. Recently hundreds of hospitals have adopted this responsible arms-length review. Mr. T. Tierney, Medicare Director, has denied these based on rulings he has created himself into a "HIM–7" Manual, which exceeds the requirements of the law and

HEW's own Regulations. On October 1, CMS filed suit on Mr. Tierney's HIM–7 Manual, to stem the tide of Bureaucratic Medi-Crisis. (Copy attached)

This Subcommittee could assert its oversight function and instruct the Bureau that Option iii Utilization Review be available to hospitals.

APPENDIX A

AMERICAN CMS BOARD OF DIRECTORS

President: José L. García Oller, M.D., 3422 Bienville St., New Orleans, Louisiana 70119.

Vice President: Noble Correll, M.D., Suite 3A, 897 SW Sixth St., Pompano Beach, Fla. 33060.

Vice President: Kenneth A. Ritter, M.D., 6109 Louis XIV St., New Orleans, Louisiana 70124.

Vice President: Nino M. Camardese, M.D., 48 N. Linwood, Norwalk, Ohio 44857.

Vice President: Robert J. Meade, M.D., 3330 Canal St., New Orleans, Louisiana 70119.

Vice President: Frank G. Veres, D.O., 4681 Mahoning Ave. NW, Warren, Ohio 44483.

Treasurer: Wesley N. Segre, M.D., 2326 Upperline St., New Orleans, Louisiana 70115.

Secretary: Edward S. Hyman, M.D., 3629 Prytania St., New Orleans, Louisiana 70115.

BOARD OF DIRECTORS BY REGION

Region 1—Jerry E. Randolph, M.D., 2966 Austin Peay Hwy., Memphis, Tennessee 38128.

Region 2—Paul E. Brady, M.D., 3789 46th Ave. S., Apt. 303, St. Petersburg, Fla. 33711.

Region 3—James H. Peoples, M.D., Acting Regional Director, 707 Phillips Road, Kinston, North Carolina 28501.

Region 4—Patrick J. McDonough, M.D., Suite 2006, 625 Stanwix St., Pittsburgh, Pa. 15222.

Region 5—Stanley Steckler, M.D., 98 Maple Avenue, Smithtown, New York 11787.

Region 6—George D. LeMaitre, M.D., 140 Haverhill St., Andover, Massachusetts 01810.

Region 7—Francis Martin, M.D., 880 South Woodward Ave., Pontiac, Michigan 48053.

Region 8—Isidro J. Amigo, M.D., 4255 Pearl Road, Cleveland, Ohio 44109.

Region 9—Graham A. Vance, M.D., 64 Old Orchard Rd., Suite 308, Skokie, Ill. 60076.

Region 10—William M. Komanetsky, M.D., 6817 Gravois Ave., St. Louis, Missouri 63116.

Region 11—Hugh V. Anderson, M.D., 2517 Seventh Ave. S., Great Falls, Montana 59401.

Region 12—Junius A. Evans, M.D., 127 South Richardson, Roswell, New Mexico 88201.

Region 13—J. William Thompson, M.D., 11100 Warner Ave., Suite 318, Fountain Valley, Calif. 92708.

APPENDIX B

GENERAL ANESTHESIA AND ASSISTANT SURGEON'S SERVICES IN CATARACT SURGERY

The Bureau of Health Insurance has recently issued a ruling regarding Medicare's coverage of general anesthesia and assistant surgeon's services in cataract surgery. Please note the following Medicare coverage determination with respect to that ruling.

It is generally customary to use a local anesthetic during cataract surgery. Thus, the use of a general anesthetic could not be considered reasonable and necessary *on a routine basis*. However, while the need for a general anesthetic is not routine, neither is it unusual. General anesthesia may be considered reasonable and necessary where it is warranted by the patient's condition. Pan-American Life will determine the reasonableness and medical necessity of this procedure on a case-by-case basis, taking local practice into consideration.

The claim should show the specific medical circumstances indicating the use of general anesthesia in order that it can be given every possible consideration.

The reasonableness and medical necessity of an assistant surgeon's services in cataract surgery will be determined by Pan-American Life on the same basis.

NORRIS V. FITZMORRIS,
Vice-President,
Consumer Relations and Medicare Operations.

Medicare Newsletter volume 9, No. 1, July–August 1975, Pan American Life Insurance Co., New Orleans, La. 70160.

APPENDIX C

FIGURE 1.

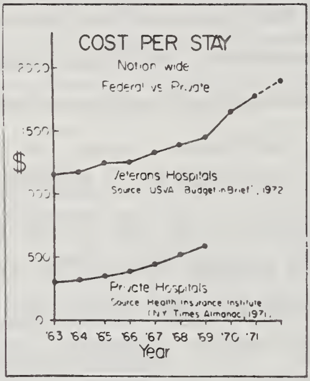
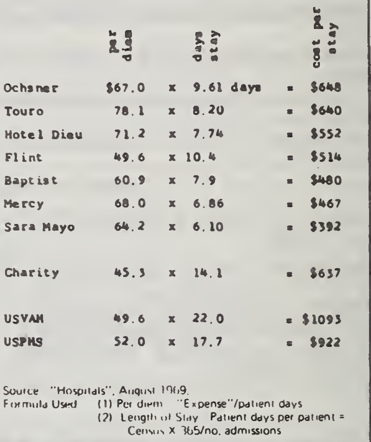


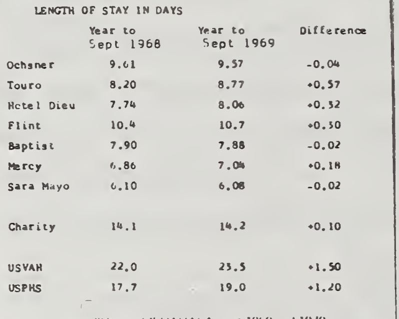
FIGURE 2.



	per diem		days stay		cost per stay
Ochsner	$67.0	x	9.61 days	=	$648
Touro	78.1	x	8.20	=	$640
Hotel Dieu	71.2	x	7.74	=	$552
Flint	49.6	x	10.4	=	$514
Baptist	60.9	x	7.9	=	$480
Mercy	68.0	x	6.86	=	$467
Sara Mayo	64.2	x	6.10	=	$392
Charity	45.3	x	14.1	=	$637
USVAH	49.6	x	22.0	=	$1093
USPHS	52.0	x	17.7	=	$922

Source "Hospitals", August 1969.
Formula Used (1) Per diem "Expense"/patient days
(2) Length of Stay Patient days per patient = Census X 365/no. admissions

FIGURE 3.

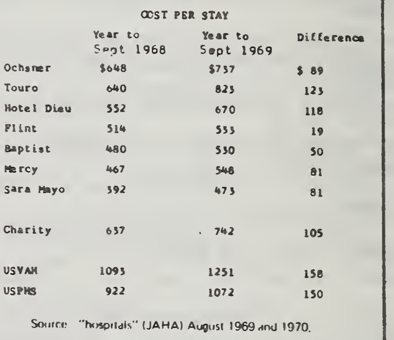


LENGTH OF STAY IN DAYS

	Year to Sept 1968	Year to Sept 1969	Difference
Ochsner	9.61	9.57	-0.04
Touro	8.20	8.77	+0.57
Hotel Dieu	7.74	8.06	+0.32
Flint	10.4	10.7	+0.30
Baptist	7.90	7.88	-0.02
Mercy	6.86	7.04	+0.18
Sara Mayo	6.10	6.08	-0.02
Charity	14.1	14.2	+0.10
USVAH	22.0	23.5	+1.50
USPHS	17.7	19.0	+1.20

Source "Hospitals" (JAHA) August 1969 and 1970.

FIGURE 4.



COST PER STAY

	Year to Sept 1968	Year to Sept 1969	Difference
Ochsner	$648	$737	$ 89
Touro	640	823	123
Hotel Dieu	552	670	118
Flint	514	533	19
Baptist	480	530	50
Mercy	467	548	81
Sara Mayo	392	473	81
Charity	637	742	105
USVAH	1093	1251	158
USPHS	922	1072	150

Source "hospitals" (JAHA) August 1969 and 1970.

Appendix D

Testimony of the Council of Medical Staffs Before U.S. Senate Committee on Finance on The Social Security Amendment of September 1970 (page 6):

6. *Infant mortality*

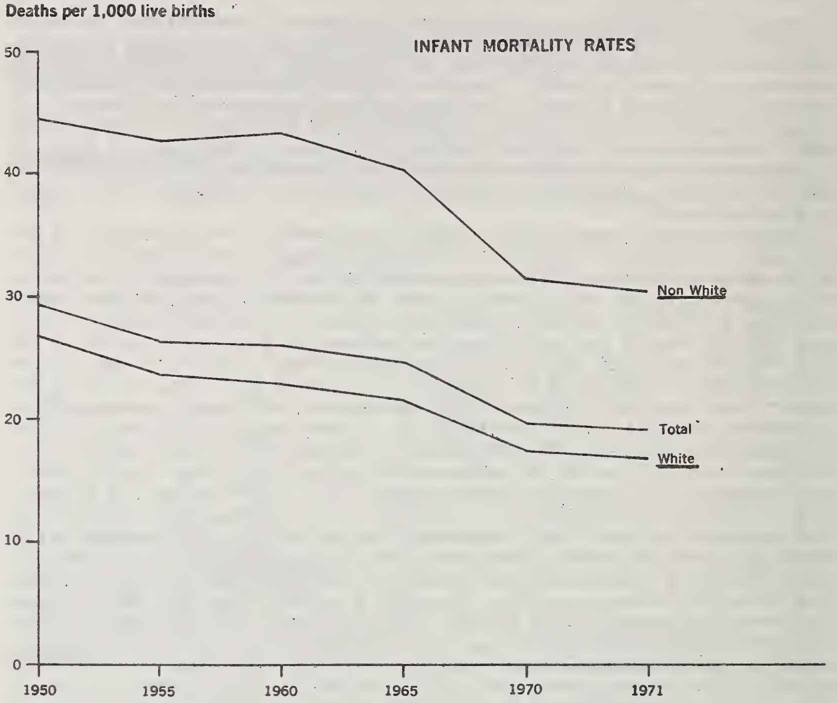
Among the propaganda to discredit the best system of medical care the world has ever known, is the constantly running statement in the press that "U.S. Health Care is second rate because we rank lower than 13 other industrial countries in Infant Mortality". The usual reference is the USPHS Monograph, Number 1000, Series 3, Number 6, International Comparison of Prenatal and Infant Morality: The United States and Six West European Countries, March, 1967. This Monograph spells out marked differences in definition of terms of neonatal death, and variations in reliability of collecting of data among the various countries. It contains qualifying remarks such as those which appear in Figures 14 and 15.

There are many reasons why a death in a newborn in one country is not recorded or counted as such in another. Sweden reports the lowest death rate of the newborn. However, in Sweden a birth need not be recorded for five years, and a neonatal death may therefore never be recorded. In many of the foreign countries referred to, the *father*, not the physician, *voluntarily* reports births and neonatal deaths, and again some are not reported and not counted. In the U.S. 97% of the babies were born in hospitals where reporting is at its best, where certification of death by physicians is required. In Sweden abortions are legal. A poor pregnancy or one in which the mother had German measles will be aborted. In the USA a deformed baby goes to term, is delivered and dies. This becomes a neonatal death, and influences the mortality figure. The criteria for a live birth are not the same: In some countries a live birth is any fetus delivered after 20 weeks, in others 28 weeks, in others any at 1,000 grams (2.2 pounds), and in others any who breathes. It is easy to draw a line at 28 weeks and say that any fetus delivered at 27 weeks who dies is a stillborn, while a death at 28 weeks is a neonatal death. There is no way to compare the 27 week fetus in one country to a 1,000 gram fetus in another. Some families have bigger babies than others at the same maturity. However, it is fair to say that the 350 gram (¾ pound) fetus counted as a fatality in Kansas is an awful lot more premature than the foreign fetus at 900 grams who dies and is not counted. Thirty-nine states in our prosperous country call the death of anything over 20 weeks neonatal. This has to be more premature than the 28 week criterion in Norway, the number three country, or in the Netherlands, the number two country. In Sweden the criterion is 35 centimeters (13.8 inches) long. How does this compare to ¾ of a pound in a skinny baby or to 20 weeks in a diabetic?

There are even tax considerations. In the United States the father loses a $600 income tax deduction if the fetus is born dead instead of dying a few minutes later. In other countries the financial tilt may be the other way. The medical decision is often arbitrary. This affects the recording of statistics.

APPENDIX E

National Health Insurance Resource Book prepared by the Staff of the Committee on Ways and Means for the Use of the Committee, April 11, 1974, page 85.



SOURCE: Statistical Abstract of the U.S. 1973. Bureau of the Census, U.S. Department of Commerce, July 1973.

APPENDIX F

National Health Insurance Proposals, Hearings Before The Committee on Ways and Means House of Representatives October and November 1971, page 61.

Expectation of life at birth, 1920 - 1968

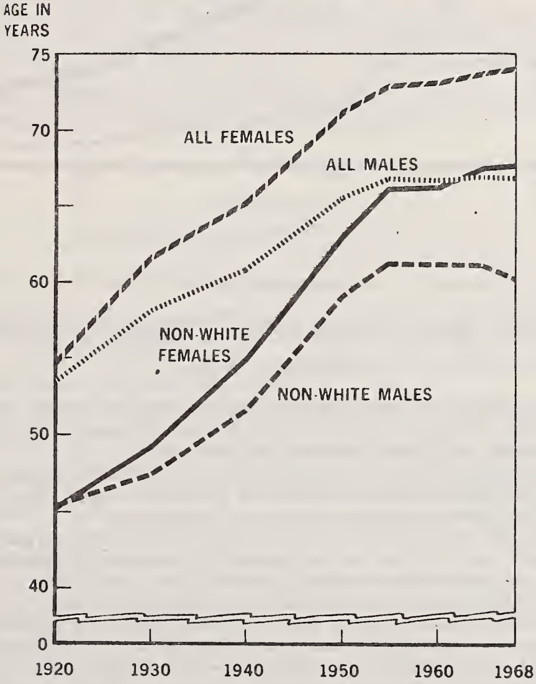


Figure A

APPENDIX F

National Health Insurance Proposals, Hearings Before The Committee on Ways and Means House of Representatives October and November 1971, page 65.

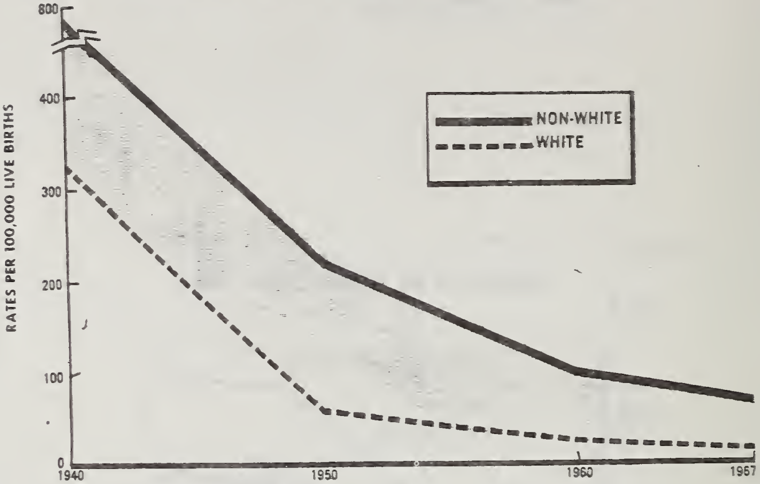

Comparison of white and non-white maternal death rates

Figure B

APPENDIX G

(Louisiana State Medical Society House of Delegates, Approved 5-2-71)

RESOLUTION #406

Introduced by: Jose L. Garcia-Oller, M.D., W. Charles Miller, M.D., Christopher Bellone, M.D., F. Michael Smith, M.D., Kenneth Ritter, M.D., Robert Meade, M.D., Wesley Segre, M.D., and Edward Hyman, M.D.

Subject: Concerning Release of Medical Information to Insurance Companies, Service Contract Corporations, Government "Carriers," and Government Agencies, from Medical Records Departments and Hospitals.

Resolved, that all inquiries for medical information will be accompanied by a properly executed and current authorization for release of information signed by the patient or his proper representative. Upon receipt of an inquiry, the Medical Record Department will submit information in the fact sheet of the chart, which includes identification data, the admitting and final diagnosis, and the name of the operations performed, including the *verified* pathological diagnosis, if any. If an insurance company requires additional information, the insurance representative will be referred to the attending physician. Requests for the "entire medical record" or "photostatic copies of the history, physical, and progress notes" are considered unethical and unacceptable; and be it further

Resolved, that it is recognized that an insurer may request under the "contestability clause" specified by the law in most states, specific antecedent information during the period of contestability. This request to the physician shall identify the specific information requested from the history of the present illness. On requests for past history, a list of such antecedent information as may be related and pertinent to the insurance policy in question will be provided by the insurer. The physician may then review the medical record(s) and can then provide the pertinent information. Operative report and pathology tissue report copies should not be necessary since the surgery is clearly listed in the front sheet and is self-explanatory as to the procedure involved and the verified pathological diagnosis, if any. Reports of X-rays, EKG or other laboratory aids used by the physician in establishing the clinical diagnosis should not be necessary; and be it further

Resolved, that for the purposes of financial audits and government provider audit programs, "the provider need only show the auditor that part of the records relating to the physician's authorization for services and not the notes made by nurses and physicians or diagnostic data which are confidential information"; and be it further

Resolved, that the physician may honor requests for unusual information of a technical nature which the patient himself may not be able to provide and not covered in 2 above; and be it further

Resolved, that certifications and recertifications are to be filed separately from the body of the medical record and shall be made available to the carrier or government agency. These should not be entered on the progress notes; and be it further

Resolved, that implementation of this Resolution shall be the responsibility of the Medical Records Committee of the medical staff.

APPENDIX H

[From Internal Medicine News, July 15, 1971]

"DECEPTION" CHARGED TO HEW IN MEDICARE, MEDICAID CHANGES

WASHINGTON.—The Council of Medical Staffs has confronted officials of the Department of Health, Education, and Welfare with evidence to show that deception was used in promulgating new regulations requiring earlier certification of Medicare and Medicaid hospital patients.

A showdown came at a meeting here presided over by Rep. Hale Boggs of New Orleans, the Democratic majority leader.

Dr. Jose Garcia Oller, president of the Council, said news releases from HEW erroneously implied that there was widespread cheating by practicing physicians in treating Medicare and Medicaid patients. He noted that data which do not exist were cited to justify a proposal to require physcian certification of Medicaid patients on the 12th and 18th days of their hospital stays rather than on the 14th and 21st as regulations now provide.

The Council asked that the proposed 12- and 18-day regulation for Medicaid patients not be adopted and that a similar regulation for Medicare, which went into effect in 1970, be rescinded.

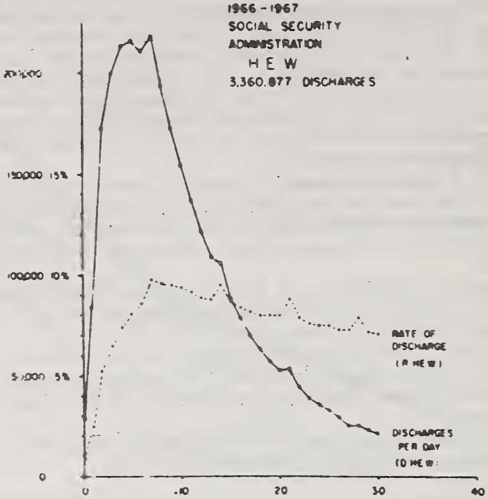
Thomas Laughlin Jr., associate commissioner of HEW's Social and Rehabilitation Service, and Thomas M. Tierney, director of HEW's Bureau of Health Insurance, said the Council's request would be studied.

The Council unsuccessfully opposed the regulation for Medicare when it was announced late in 1969. A news release from the Social Security Administration, dated Oct. 13, 1969, was challenged as being deceptively misleading.

The release said the new regulation "is expected to shorten hospital stays and thus reduce Medicare costs."

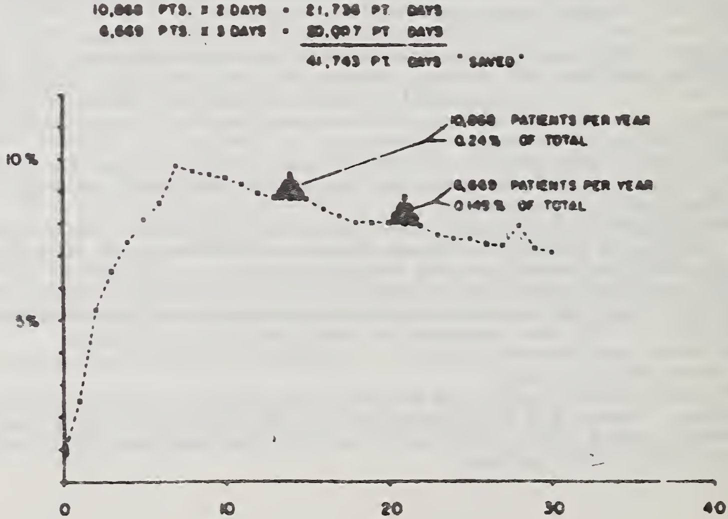
"To illustrate the potential cost savings to the program," the release continued, "Secretary (Robert H.) Finch noted that if each hospital stay by a Medicare beneficiary during 1970 is shortened by one day, Medicare costs will be reduced by approximately $400 million."

Dr. Garcia Oller said the $400 million figure used in the release was allowed to stand despite specific advice from Robert J. Myers, then chief actuary for HEW, that the actual savings would not be more than $5 million.



Vertical axis indicates number of patients discharged on the left column and discharge ratio on the right column. Horizontal axis indicates day of hospitalization since admission.

The curve shows 109,053 patients were discharged on the 13th day and 106,761 on the 14th day. This actual drop in discharges is a small shoulder in the cure of discharges (HEW), but becomes a peak in HEW's "discharge ratio." The tiny rise at 21 days and the unnoticeable rise at 28 days are also amplified into peaks by HEW and scribed to "certification." Yet there is no certification on the 28th day, a Council spokesman notes.



Vertical axis indicates discharge ratio and the horizontal axis indicates days in hospital for the period October, 1966, June, 1967.

The HEW claim of $400 million savings is fraudulent, says a spokesman for the Council of Medical Staffs. The correct estimate would be $4.7 million, at $100 per diem. Assuming the peaks of the ratio of discharge at 14 and 21 days are caused by certification and assuming that peaks are the tremination of "unnecessarily prolonged hospital stays," HEW claimed to save $400 million by pushing these peaks back through a change in certification dates. If the 14 day peak is moved 2 days and the 21 day peak is moved 3 days, the saving would be 41,743 patient days per year nationwide. At a generous $100 per diem this amounts to $4.17 million, not $400 million as claimed by HEW. HEW was aware of this error when the claim was made, the Council spokesman says.

Mr. Myers calculated that to shift the peak discharge rate to the 12th and 18th days "is to reduce the average days of hospitalization by discharge by .014 days, which represents a savings of $5 million per year."

The 1969 HEW release contained the statement:

"Data on length of stays in hospitals under the (Medicare) program show that the number of discharges rises significantly on the 14th day and again on the 21st day," Secretary Finch said. "Since there is no apparent medical reason why discharges should peak on these days, it seems reasonable to conclude that the requirement for certification and recertification on certain days is in itself a factor contributing to the larger number of discharges on such days.

"We expect that a reasonable shortening of the certification periods will result in some decrease in the number of unnecessarily prolonged hospital stays."

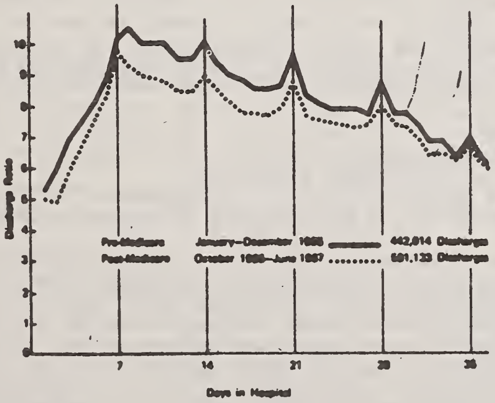
Dr. Garcia Oller said a reader of this release would infer that practicing physicians were cheating the government by holding patients in hospitals without medical cause.

Illustration 2

DISCHARGE RATIO BY DAYS' STAY IN HOSPITAL

Patients 65 and Older Pre- and Post-Medicare

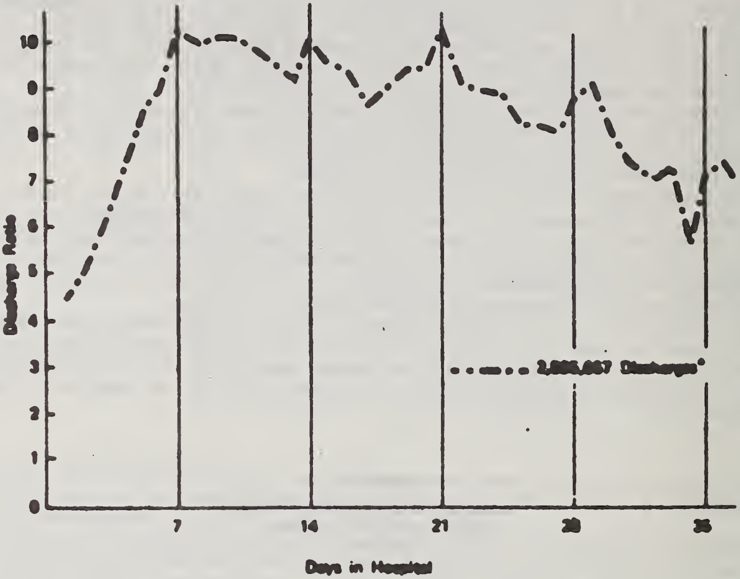
PAS Data



PAS data shown above establishes that the insignificant peaks of discharge ratios antedate Medicare and could have no relation to the requirement to certify.

In addition, he cited HEW's own statistics showing that in the period October, 1966-June, 1967, the discharge of Medicare patients actually dropped from 109,053 on the 13th day to 106,761 on the 14th. These were 52,924 discharges on the 20th day, 53,614 on the 21st.

He stated that a discharge ratio invented by HEW to amplify minor deviations in the curve of discharges showed insignificant peaks on the 7th, 14th, and 21st days. HEW attributed these peaks to the Medicare requirement for certification and regarded this as proof that the regulation was effective in terminating "unnecessarily prolonged hospital stays." But, the Council noted, figures compiled by the Professional Activity Study of the Commission on Professional and Hospital Activities showed identical peaks for patients 65 years and older even before Medicare was established. This proves that the peaks were not the result of Medicare certification, he said, SSA did not collect this control data before making its assertion.



Certification change in 1970 fails to move discharge ratio peaks. On January 1, 1970, Medicare regulation was changed to require certification to the 12th day and recertification to the 18th day. If successful, the regulation would have moved the 14- and 21-day peaks to the 12th and 18th days. As shown, there was no change in the discharge pattern. Yet on March 30, 1971, HEW claimed that the Medicare regulation had "reduced hospital stays significantly," the Council spokesman notes.

"Thus the regulation really had no effect, and the rationale does not support the regulation," Dr. Garcia Oller commented.

An HEW news release on March 30, 1971 announced the department's intention to extend the 12- and 18-day regulation to Medicaid. A paragraph in the release read:

'Experience with Medicare has shown that requiring certification or recertification by physicians reduces hospital stays significantly,' Federal Social and Rehabilitation Administrator John D. Twinane said. 'Applying this requirement to Medicaid can cut its costs without lowering the quality of care. Thus we can provide for needed medical care, without unnecessary costs to the taxpayers.'"

The Council asked Rep. Boggs to obtain the data on the experience with Medicare which the news release cited, and was told by the Congressman: "The data used to justify the proposed regulations relative to certification and recertification of Title XIX . . . is the same as that developed by the SSA in 1969."

"HEW said the experience with Medicare justified the new regulation for Medicaid, yet the department can cite no data to back up the claim," said Dr. Garcia Oller. Data on the effect of the new regulation do exist and have been published. A PAS study on a comparable number of Medicare discharges has shown that there has been no change in the 14- and 21-day discharge ratio peaks in spite of the change in certification to the 12th and 18th days in January, 1970.

By HEW's own yardstick, therefore, the Medicare experience with the January, 1970, regulation does not justify the claims of any savings or benefit from the certification regulation made in the March 30, 1971, HEW news release, Dr. Garcia-Oller said.

State Sen. William J. Guste Jr. of New Orleans, who made the Council's presentation at the Washington meeting, asked that the Medicaid regulation not be put into force because it is "unwarranted, unnecessary, ineffectual and against the public interest."

The Council was represented by members of its executive committee, including Dr. Garcia Oller; Dr. Kenneth Ritter, vice-president; Dr. Robert Meade, vice-president; Dr. Edward S. Hyman, secretary; and Dr. Wesley Segre, treasurer.

HEW officials present included Mr. Laughlin; Mr. Tierney; Hugh Johnson, assistant SSA commissioner; Al Richter and the Rev. Homer Jolley, of the Medicaid administration.

Aides of Louisiana senators and representatives also attended, along with Rep. Boggs himself.

The Council of Medical Staffs lists a membership of more than 20,000 practicing physicians on the staffs of 300 hospitals in a dozen states. There are chapters in California, Louisiana, Michigan, Ohio. Texas, Florida, New Jersey, Kansas, Oklahoma, Minnesota, Nevada, New Mexico and Rhode Island.

Mr. Rostenkowski. Thank you, Doctor.

Are there any questions of the witness?

Mr. Waggonner. Mr. Chairman? I don't have any questions, but I would like to welcome my Louisiana friends here after the fact. I was called from the room. Governor Carey is in town, and you can guess what his mission might be. But I used to be on his committee, and I went to spend a little time with him.

I do want to welcome you to this committee.

Dr. Oller. Thank you. The city of New York has the same problem as the Federal Government, paying its bills, and our recommendations today are to see that the bills are paid for those who need it, and the money tree is drying up. We cannot give it away to everybody. Let's take care of the sick first.

Mr. Waggonner. Thank you.

Mr. Rostenkowski. Our next witness is Dr. Marvin Belsky.

STATEMENT OF MARVIN BELSKY, M.D., ON BEHALF OF NEW DIMENSIONS IN COMPREHENSIVE HEALTH

Dr. Belsky. Thank you for inviting me to be here today. My name is Marvin Belsky, and I am a practicing internist of more than 18 years. I am speaking on behalf of New Dimensions in Comprehensive Health, which is a nonprofit organization of health professionals interested in innovative ideas in health care delivery.

The delivery of medical care in the United States today is undergoing a process of fundamental reappraisal. New laws and new forms will undoubtedly come into being. All of us may soon be covered by national health insurance. Health maintenance organizations, known as HMO's are gaining popularity. Doctors are increasingly undergoing periodic competency reviews by their peers. But all such new forms and procedures deal primarily with the economics and technology of medical care, not its humanity or capacity for partnership between doctor and patient.

Quality care requires a secure economic basis and the very best technology. But quality care depends on concerned, humanistic communication. Without it, the doctor is handicapped and the patient endangered.

The combination of exotic new technology and bureaucratic forms of medical delivery make an effective doctor-patient partnership more urgent than ever. Unless the patient learns to participate in his own health enterprise, his care will become more and more depersonalized and remote.

Various health insurance plans proposed concern themselves, among other things, with payment for treatment, access to medical services and health care, diffusion of technology and new techniques, peer accountability by physician, and consumer input on health planning councils and advisory boards.

Regrettably not enough concern or attention has been given to the likely possibility that, with broader availability of health services, there will be increased depersonalized and uncommunicative care than at present. There has been, and there is, little recognition that the patient, as consumer, must participate in the therapeutic process with the health care provider as the key to success of his or her own well being.

Presently, physicians are thought of by the public as someone to turn to when illness or disability occurs. The physician is highly regarded—even held in awe—as a healer. Doctors easily acquiesce in this role and their exceptional training and social status reinforce feelings of separateness. Insufficient emphasis is placed on the physician's role as a teacher. Nor is recognition given to the patient consumer as an individual who, given relevant information in a motivating way, can and will actively participate in his or her own health care and learn effective health behavior as a way of life.

Presently, 94 cents out of every health dollar is spent on treatment, 4 cents on research, and of the remaining 2 cents for disease prevention, only four-tenths of a cent goes toward health education and none on patient consumer input to care. The effect of this incredibly skewed emphasis toward disease treatment may be to increase the total social cost of health care by the expense of treating sickness which may have been prevented, treating diseases and infirmities whose course may have been of shorter duration, treating recurrent incidents of such diseases involving the cardiovascular system, the pulmonary system, diabetes, and the like, which may be avoided by proper health maintenance by the patient.

Needless to say, the costs relating to loss of work and productivity to the individual and his or her family, to industry, agriculture, and government, are considerable when the Nation gives only lip service to disease prevention.

The physician and the projected expanded health care system have significant roles to play as teachers and dispensers of good health behavior, considering that the number of physician visits in the United States are now running at the rate of 1 billion per year.

The health care system can serve as health educators to focus on health maintenance disease prevention prevention, patient respousive health maintenance, disease prevention, patient responsiveness to medical instructions and guidance. Many studies indicate at least one-third to one-half of patients do not comply with doctor recommendations or drug regimens, at least in part or in whole, with resulting wanted diagnoses, wasted drugs, wasted X-rays and wasted opportunities for well being. This waste may be multiplied with the advent of broader health coverage if steps are not taken to more actively involve the patient in good health practices.

A truly well-informed patient public which is expected to know and is encouraged to learn may well reduce malpractice, not directly associated with outright incompetence, because, as consumers, they will look for and get signals from the physician. Informed consent from a well-informed patient in the context of a truly therapeutic relationship will enhance the total care environment reducing antagonistic roles.

In any new legislation, the patient, as consumer, will undoubtedly be represented at the macro-level on boards of health delivery systems and on advisory boards of governmental regulatory bodies. HMO's, hospitals, perhaps even PSRO's, may have consumer represenatation, but ony legislation must facilitate and integrate the individual patient consumer in an assertive, informed relationship with providers, be they doctors, nurses, paramedical personnel, or institutions.

Therefore, we would propose that any health insurance scheme enacted by Congress should encourage grassroots patient consumer participation by:

(a) Underwriting or compensating through reimbursement patient education at the "teaching moment" in the health care facility or physician's office by doctors, nurses, and professional health educators as part of a health care team. (More than 70 percent of present care is now provided by private practitioners.) Making available coverage for providing health education and motivation may reduce the total health bill compared to a system without it.

(b) Underwriting or providing reimbursement to health care providers (be they institutions or private practitioners) for encouraging direct patient feedback mechanisms in small groups to heighten awareness of doctor-patient/provider-user roles and responsibilities and thereby increase patient motivation toward effective health behavior. A number of hospitals now increase their effectiveness by including a patient ombudsman on their staff to relate to patient complaints and to motive patients in good health practices when they leave the hospital.

(c) Underwriting or subsidizing the training of health educators and paramedical personnel to serve on the staffs of hospitals, HMO's, group practices, and perhaps with private practitioners.

(d) Underwriting and supporting medical school curriculum changes designed to explore and reinforce the physicians's role as teacher, as well as healer, and to encourage a more communicative relationship of the doctor to the individual patient, the community, and to other health care providers. There is now little encouragement for the medical student to increase his human relations skills as overwhelming emphasis is on technology.

(e) Underwriting and supporting studies to evaluate whether patient education at the individual and community level is effective, as opposed to the cost of benefits of operating a health care system without an important health education component. Consideration should be given to broken appointments, patient failure to follow advice, recurrence of illness that may have been averted or delayed and broader social costs, such as lost productivity and disruptions.

(f) Supporting a system which would emphasize well being, nutrition, exercise, disease prevention, and the health maintenance system—a system which would involve the patient consumer in a two-way therapeutic relationship with the physician, health educator, and other health care providers.

As presently offered, many national health insurance proposals will aggravate the present alienating, deteriorating relationship. We may only be buying technology over personal medicine without achieving maximum results for the dollars spent.

We urge concrete initiatives and incentives for providers to encourage patient consumer participation in their own well-being and health maintenance.

Mr. Rostenkowski. Thank you, Doctor.

I noted in the beginning of your statement, you talked about personal care and the doctor-patient relationship should national health insurance be enacted.

Do you not really see quite an impersonal relationship growing today without national health insurance?

Dr. Belsky. I think the problem is irrelevant to the forum. In other words, what I am saying is, whether you have HMO's, fee for service, or some form of national health insurance, you will have patients who are lacking skills in patienthood, who are frightened by being sick, and they are in awe of a doctor. They are very often even lacking skills in knowing what questions to ask.

Mr. Rostenkowski. Shouldn't the Government assist in educating our population to the understanding that they shouldn't be afraid, and teaching people through a policy established by the Government that they should be aware of their illness, that they shouldn't have undue apprehension of a doctor?

That is just an attitude, I think, that has come to pass, and people are just too afraid of being sick.

But I am talking about the general atmosphere that exists today. I have known quite a few patients who feel like an IBM card, today, in visiting even what one would have called a family doctor. I see that with my own children. I am sure the recordkeeping is tremendously important, but it is almost as if the relationship has dwindled, where it is almost a matter of taking the next card out and reading it. There is no personal care.

I don't know if that wouldn't worsen if we passed national health insurance. But I think generally speaking in a relationship, in patient-doctor relationships, and even in student-professor relationships, the whole attitude of our society today has become quite impersonal. I feel that if, in the future, the Government should become active in an educational program, particularly in health, I am one of those that believes that preventive medicine is the best and the cheapest form.

I appreciate your statement, and it was very nice of you to come and share with us your views.

Would you like to add anything?

Dr. Belsky. It is precisely that particular point. It is not that I have any opposition to national health insurance. I recognize the fact of the increasing necessity for the Government to enable its citizens to get equitable medical care of high quality. What I am fearful of, unless some preventive steps are enacted into law, is that what we will be getting is more rushed medicine, more patients who will say, "My doctor doesn't talk to me."

In essence, what we are suggesting is that in framing new legislation for national health insurance, that legislation will be buying a pig in a poke, unless you write into the law some frame of enabling, or factor for enabling, the consumer to develop skills on how to question the doctor, to have consumer feedback mechanisms, where if he is treated coldly, or arrogantly, he has a forum in which he can speak up.

It is precisely because of the danger that the impersonal medicine we see today may be emphasized, that legislative action is needed. I think there are people who want value for their money, and as much as the complaints about cost of medical care are heard, we hear again and again the call of patients of, "My doctor doesn't speak to me."

Therefore, much more widespread than patients coming to physicians with complaints, far and away, they are simply staying away from the medical care system. Unless something is done to educate the consumer and to develop a consumer feedback mechanism, we will have an increasingly alienated form of medicine in this country.

Mr. ROSTENKOWSKI. Thank you.

This concludes the hearings today. The subcommittee will stand in recess until 9 tomorrow morning.

[Whereupon, at 12:30 p.m., the subcommittee adjourned, to reconvene at 9 a.m., Friday, November 7, 1975.]

NATIONAL HEALTH INSURANCE

FRIDAY, NOVEMBER 7, 1975

U.S. House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in the committee hearing room, Longworth Office Building, Hon. Dan. Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. The subcommittee will come to order.

Welcome to the subcommittee, Mr. Rathgeber, we are certainly looking forward to your testimony. If you will identify yourself and the gentlemen with you and proceed with your testimony, the committee is ready to receive it.

STATEMENTS OF FREDERICK E. RATHGEBER, EXECUTIVE VICE PRESIDENT, PRUDENTIAL INSURANCE CO. OF AMERICA, ACCOMPANIED BY DANIEL W. PETTENGILL, VICE PRESIDENT, AETNA LIFE & CASUALTY, AND LESLIE P. HEMRY, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN LIFE INSURANCE ASSOCIATION, AND THE LIFE INSURERS CONFERENCE

Mr. Rathgeber. My name is Frederick E. Rathgeber. I am executive vice president of the Prudential Insurance Co. of America. With me are Mr. Daniel W Pettengill, vice president of the Aetna Life & Casualty, and Mr. Leslie P. Hemry, president of the Health Insurance Association of America. We appear today on behalf of the Health Insurance Association of America, the American Life Insurance Association, and the Life Insurers Conference. The 500 member companies of these associations provide more than 90 percent of the private health insurance underwritten by insurance companies in the United States.

This marks the third occasion that the associations which we represent have been before the Ways and Means Committee on the important issue of health care in this country and, more particularly, on national health insurance legislation. As we indicated in prior appearances in 1971 and 1974, we strongly support the early enactment of a national health insurance program which would provide comprehensive insurance coverage to all Americans so that they can have access to quality medical care at a price they can afford. This objective can be most economically and efficiently achieved by modifying and improving the current health care delivery and insurance system, rather than by destroying it and building anew with uncertain prospects of performance and efficiency. Specifically, we support the principles of any bill patterned along the lines of the National Health Care Act of 1975 (H.R. 5990). This bill was introduced by Congressman Burleson of your subcommittee.

In view of the lengthy debate over the issue of national health insurance, and inasmuch as our associations have testified at great length on prior occasions, I will limit my oral statement today to a summary of where our business stands on the national health insurance issues which have not as yet achieved a national consensus. I have with me a more complete statement of where we stand on the overall subject and I would request your permission to file the complete statement for the record.

Mr. ROSTENKOWSKI. Without objection, so ordered.

Mr. RATHGEBER. At the outset, let us take a brief look at some of the events which have transpired in this country during the last 18 months. We have witnesed a major recession with accompanying heavy unemployment, coupled with a continuation of inflation which has been reflected in escalating health care costs. The Federal budget deficit is now running at a level of at least $60 billion a year and there is a real possibility that some local governments will default on their obligations. These developments have drawn the attention of legislators at all levels of government to certain realities of life. There is no pressing demand on the Congress for increased Federal encroachment into the private sector, larger Federal budgets, larger deficits, or increased taxes. It is becoming increasingly obvious that the public is becoming more concerned about the magnitude of these matters. They see the need to allocate our resources carefully among such essentials as defense, education, energy, the environment, food, housing, transportation, unemployment benefits, and welfare as well as health care. This country, rich as it is, does not have unlimited resources.

Against this background, how best and in what form should a national health insurance program be financed? Under whose auspices should it be administered? How should the continuing problem of the costs and quality of health care be dealt with under a national health insurance program? Other questions relate to the design and scope of the national health insurance benefits. We respectfully suggest that the Congress take a realistic approach toward resolving these questions.

There are two contrasting principles for the financing of a national health insurance system. The first would produce all funds from Federal sources through increases in social security payroll taxes and/or Federal general revenues. The second would provide most of the financing, as now, through premiums paid by employers and employees, limiting tax dollars to be used where necessary to pay for the costs of the poor and near poor. We are of the strong opinion that the second principle makes the best sense for Americans at any time, especially in this particularly difficult period. Our business believes that it is not in the public interest for national health insurance to be wholly financed through Federal taxes. We reach this conclusion for the following reasons:

1. The use of such financing would make the Federal Government the sole purchaser of medical care. Such a monopoly is not desirable for the public, the providers, or the Government.

2. Americans do not want an additional tax burden. The combined employer-employee social security tax on a worker's wage has more than doubled in just 5 years. Currently, half the families in the United States are paying more in social security taxes than they are in income taxes.

3. It is essential to protect the basic OASDI system and not further complicate its problems by sweeping national health insurance into the Social Security Act. The social security system itself is undergoing careful scrutiny because of the fiscal problems posed by high inflation and falling birth rates.

4. Each tax dollar for health care is a tax dollar not available for other social priorities such as housing, nutrition, and ecology—all of which have a direct impact on the health of the Nation.

There are, likewise, two major contrasting principles for administering a national health insurance program. The first would have the Federal Government undertake the entire administration of the program. This would require the establishment of an enormous Federal bureaucracy. The second would provide for the fullest utilization of the existing administrative and underwriting knowledge of private health insurers. We are of the firm opinion that it would make the most sense for America to utilize fully the knowledge of the private health insurance system with its vast corps of experienced personnel. This should be done with appropriate governmental supervision. We reach this conclusion for the following reasons:

1. Establishing and operating a national health insurance program is an effort of enormous scope and complexity. This requires the experienced and capable management system and personnel which is already in place, and functioning efficiently.

2. Private health insurers can do the job more efficiently than the Government. For example, the cost of administering medicare under social security is about 6 percent of total claim volume. In contrast, the administrative costs of the Federal Employees Indemnity Plan, which is operated entirely by private insurers, is less than 4 percent, exclusive of premium taxes. A recently published governmental study further confirms the greater efficiency of the private sector.

3. To wipe out an important part of the private sector of the economy, involving some half a million persons, and to replace them with a Federal bureaucracy, would be unprecedented in our Nation's history, enormously disruptive and costly. Significant destruction of business patterns with loss of jobs would be just the primary impacts.

4. Most people already have health insurance. Well over 172 million Americans (including 12 million with coverage supplementing medicare) have private health insurance as a result of aggressive and innovative plan design, underwriting, and marketing. Some 150 million have already been provided with sufficiently adequate coverage to ease the heavy financial burden of catastrophic illness, and high limit catastrophe coverage continues to grow rapidly.

The serious questions of the cost and quality of the health care that will be delivered under national health insurance must be dealt with realistically by the Congress. Quality of health care is something that cannot be mandated by fiat. Instead, it is essential that Congress exert the leadership necessary to make sure that insurance carriers, doctors, hospitals, and other health personnel work together to establish effective cost control and quality assurance mechanisms. Only then can a national health insurance program be adopted with reasonable assurance that quality care will be available at an affordable cost. We respectfully submit that many of the steps in the direction of a solution to this important question are provided in the National Health Care Act of 1975.

This act calls for the expansion or establishment of cost controls and quality assurance programs. All payments for health care under federally supported programs would be tied to prevailing charges and to peer review of those services and charges that fall outside of professionally established guidelines, assuring appropriateness of treatment, quality of care, and reasonableness of providers' charges.

The act would also help contain costs by encouraging the development of comprehensive ambulatory health care centers where primary care can be delivered on a coordinated and economical basis. By making such care available, much unnecessary use of costly inpatient hospital care can be avoided.

The act would increase the supply and improve the distribution of health care personnel by adding or continuing grant and loan programs needed to train health care personnel and by incentives for such personnel to serve in areas designated as health scarcity areas, including rural regions and core city areas.

This legislation would make comprehensive health insurance available to all Americans. It sets the same minimum benefit standards for all types of health insurance coverages: Those provided by employers, those purchased by individuals, and those provided by a State for its financially disadvantaged residents. The benefits under these plans would be phased in over time so as not to overtax the delivery system and cause undue increases in the costs of health care.

Costs for the expenses of a catastrophic illness are covered with no dollar limit. There would be modest deductibles and copayments with a $1,000 limit on total copayment and deductible charges per family in any benefit year. For the poor and near poor, this limit would be scaled down even further.

The unemployed would be adequately covered. These individuals would be protected at their place of employment for at least 2 months after they have been laid off. If still unemployed after that period, and not capable of self-support, they would be enrolled in a State plan with the same minimum benefits as are established for employer-employee plans.

The poor and near poor would qualify for a State health care plan, which would be subsidized by the State and Federal Governments and insured by private insurance carriers. Those who are self-supporting but deemed uninsurable would be enrolled separately, with the risk covered completely by the private health insurance system.

The National Health Care Act of 1975, introduced in the Congress by Congressman Omar Burleson of Texas (H.R. 5990) and by Senator Thomas J. McIntyre of New Hampshire (S. 1438), contains the essential balance of public, governmental, and private participation. It is realistic. It puts tax dollars only where they have to be spent. The private sector assumes the responsibility for providing coverage for those self-supporting individuals previously deemed uninsurable. The National Health Care Act uses the tax system to encourage compliance with Federal health benefit standards. It uses private insurers for what they can do best—to provide know-how in plan design, marketing, actuarial, claims services, and working with providers in areas of cost and quality assurance. And it uses Government for what it can do best—for oversight regulation, to set standards, to provide for orderly change, to lay the groundwork for the continued pursuit of quality health care for all at a price we can afford to pay, and to provide funds for the poor and near poor.

We offer the complete cooperation and assistance of the associations which I represent in working out an appropriate national health insurance program which will be in the best interests of the American public.

[The prepared statement follows:]

Statement of the Health Insurance Association of America, American Life Insurance Association, and Life Insurers Conference

THE CURRENT PERSPECTIVE WITH RESPECT TO NATIONAL HEALTH INSURANCE LEGISLATION

The primary purpose for enacting national health insurance legislation, we believe, should be to make private comprehensive insurance coverage available to all Americans so that they can have access to quality medical care at a price they can afford. This objective can be most economically and efficiently achieved by modifying and improving the current health care delivery and insurance system, rather than by destroying it and building anew, with uncertain prospects of performance and efficiency.

The debate over national health insurance is not new. There are numerous bills that have been introduced in this session of Congress that are essentially unchanged from bills introduced in the previous session and in sessions before that. The debate has, however, changed the nation's perspective. There is now a heightened sense of realism concerning national health insurance legislation. This is in part due to our growing knowledge of the complexities of the health care system and to our awareness that our national resources are severely limited, and will remain so limited for the foreseeable future. There are a number of realities which exist today that form a rather severe backdrop for discussions of national health insurance. These realities should influence the nature and shape the content of any proposal that eventually passes the Congress.

First, any proposal must carefully blend the use of essential public funds and governmental authority with the experience and proven capacities of the present health care system. The government should set standards, provide for orderly change, lay the groundwork for the faster pursuit of quality health care at a price we can afford to pay, and provide financing for the poor and near poor. Private insurers should provide their know-how in plan design, marketing, actuarial, claims service, and work with providers in areas of cost and quality assurance.

Second, it seems to us that any proposal that calls for enormous new government expenditures to be financed by new taxes of equal magnitude cannot win public support and should not be accorded serious congressional consideration. The public is not pressing Congress for increased Federal encroachment into the private sector, larger Federal budgets, larger deficits and increased taxes. It is becoming increasingly obvious that the public would like the magnitude of each of these to diminish rather than increase.

The third reality is that this country, rich as it is, does not have unlimited resources. We must allocate our resources carefully among such essentials as defense, education, the environment, food, housing, transportation, unemployment compensation, and welfare, as well as health care. A number of these areas have equal or greater impact upon health than health care per se. Health care expenditures now constitute 8.3 percent of our growing GNP, up from 5.9 percent ten years ago and 4.6 percent 20 years ago. Any national health insurance proposal must seek to cope with the ever increasing demand for health care services, some of which cannot be related to improvement in the nation's health.

A fourth reality is that in many rural and inner city areas lack of health manpower and facilities is an even greater deterrent to securing necessary health care than lack of money. Congress is to be commended for its recognition of this factor and for its efforts to assure more manpower and to improve the health care delivery system through passage of the various manpower acts, the Health Planning and Resources Development Act, and the HMO Act. Regrettably, progress under this last act has been slow due to provisions that are discriminatory or unduly restrictive.

Still another reality is the coming together of views of major groups in the private sector of the health care field. The medical profession and other health care providers, insurers, employers, and an increasing proportion of the general public agree that a private insurance program, not a government monopoly of health insurance (and ultimately health care), is best with government subsidies applied only where there is no possible alternative. This developing consensus would appear to be growing in strength and commitment.

A further reality has to do with the American life style. We are a country that smokes too much, drinks to excess, lives in a success oriented-tension creating atmosphere and drives our high horse-powered cars at reckless speeds. As Fuchs has said:[1] "A great deal of what has been written recently about 'the right to health' is very misleading. It suggests that society has a supply of 'health' stored away which it can give to individuals and that it is only the niggardliness of the Administration or the ineptness of Congress or the selfishness of physicians that prevents this from happening. Such a view ignores the truth of Douglas Colman's[2] observation that 'positive health is not something that one human can hand or require of another. Positive health can be achieved only through intelligent effort on the part of each individual. Absent that effort, health professionals can only insulate the individual from the more catastrophic results of his ignorance, helf-indulgence, or lack of motivation.' The notion that we can spend our way to better health is a vast oversimplification. At present there is very little that medical care can do for a lung that has been overinflated by smoking, or for a liver that has been scarred by too much alcohol, or for a skull that has been crushed in a motor accident."

Finally, there is the reality of a lack of precedent for a complete government takeover in this country of a function in the private sector, where that function has been reasonably and responsibly performed. In the recent debate on the new pension law, there was no proposal for a government takeover of the private pension business. In the current debate on no-fault insurance, there is no serious proposal to take over the auto insurance business. It would follow that there is no good reason for the government to create its own monopoly over national health insurance and eliminate private insuring organizations.

A totally government financed and administered national health insurance program is not in the public interest and would constitute a great danger to the country. The principal danger is that once we go that far, the extension of government control over all aspects of health care becomes inevitable. Once into the health area, pressures would begin to build for similar government extension into other areas of the economy. There would be no turning back. And who is to say that government can do the job better? If we are not absolutely certain of that proposition, we had better revise the present system where it needs revision rather than substituting an untried and unworkable bureaucratic government monopoly.

Goals and objectives of a national health insurance program

The following is an outline of appropriate goals for a national health insurance program:

1. It should provide as comprehensive a scope of benefits as practical to all, regardless of income level.

2. It should allow for phasing in an expansion of coverage so that the health care system will become capable of delivering the health care expected by the population. Immediate, unlimited coverage would overburden the health care system and would result in unfulfillable expectations, not to mention the potential inflationary impact.

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[1] Who Shall Live, Fuchs, Victor R., Basic Books, Inc., pages 27 and 28.

[2] "National Goals and Objectives" (speech by J. Douglas Colman at National Health Forum, Chicago, Illinois, March 20, 1967).

3. It should address the entire matrix of national health problems: Sharply rising costs; inadequate access to coordinated comprehensive health care for many Americans; need for facility and manpower planning; lack of effective, economical programs to assure quality health care and appropriate utilization thereof for all Americans; uneven benefit levels.

4. The solutions should involve blending the expertise and strengths of all elements of the private sector with the special capabilities of Federal and State governments to set needed standards, to provide regulatory oversight, and to finance the care of the poor and near poor.

5. It should include an equitable method of financing with minimum reliance on additional federal financing, continuing reliance on private insurers, and without resort to the overburdened Social Security system.

6. It should emphasize cost effective services, with special consideration of less costly ambulatory-type care as opposed to more costly institutional care.

These goals and objectives were selected after considerable discussion over the past six years among leaders within all sectors of the health care delivery and health insurance industries. They reflect an increasing sense of realism concerning what a system of universal health insurance can be expected to achieve and what resources, above and beyond what are currently being utilized, are available for its implementation. We believe that enactment of the essential features of the National Health Care Act of 1975 would be a pratical way of achieving these goals.

The National Health Care Act of 1975 (H.R. 5990)

The National Health Care Act, among the health insurance bills introduced in Congress, is best suited to achieve the aforementioned goals. First, it calls for the expansion or establishment of cost controls and quality assurance programs. All payments for health care under Federally supported programs would be tied to prevailing fees in the case of non-institutional services and to prospectively approved rates in the case of institutional services. All services would be screened against professionally established standards with professional review of those services that fall outside the standards, assuring appropriateness of treatment and quality of care. The Act would also help contain costs by encouraging the development of comprehensive ambulatory health care centers where primary care can be delivered on a coordinated and economical basis. This encouragement comes through the awarding of grants and loans for the construction and modernization of these centers. By making such care available, much unnecessary use of costly in-patient hospital care can be avoided.

The Act would increase the supply and improve the distribution of health care personnel by adding or continuing grant and loan programs needed to train scarce health care personnel and by incentives for such personnel to serve in areas designated as health scarcity areas, including rural regions and core city areas.

This legislation makes comprehensive health insurance accessible to all Americans. It sets the same minimum benefit standards for all types of health insurance policies: those provided by employers, those purchased by individuals, and those provided by a State for its financially disadvantaged residents. The benefits provided by these plans would be phased in over time so as not to overtax the delivery system and cause undue inflation. Ultimately, there would be a broad range of benefits for everyone regardless of income or physical condition.

Costs for the expenses of a catastrophic illness are covered. There is no dollar limit. There would be modest deductibles and copayments, with a $1,000 limit on total copayment and deductible charges per family in any benefit year. For the poor and near poor, this amount would be scaled down according to income.

The unemployed would be adequately covered. These individuals would be protected at their place of employment for at least two months after they have been laid off. If they are still unemployed after that period and not capable of self-support, they would be enrolled in a State plan with the same minimum benefits that are established for employer-employee plans.

Among the standard plan provisions required are: provisions to continue coverage for an employee absent due to illness or injury; provisions to allow disabled dependent children to be covered; and provisions to continue coverage during employment changes.

The poor and near poor would qualify for a State health care plan, which would be subsidized by the State and Federal governments and insured by private insurance carriers. Those who are self-supporting but deemed uninsurable would be enrolled separately, with the risk covered completely by the private health insurance program.

As an inducement to employers with below average benefit plans to bring such plans up to the minimum benefit levels suggested in the Act, the bill provides that a health benefit plan which does not meet minimum standards in 1977 would lose 50 percent of its allowable income tax deduction attributable to the plan. After 1978, the deduction would be totally eliminated unless the minimum standards were met.

The role of private health insurance

Private health insurance is now providing a valuable service to an overwhelming portion of the population as demonstrated by the fact that coverage under group and individual plans has already reached almost nine out of every ten American civilians, with a corresponding rapid expansion of the comprehensiveness of the coverage provided. The growth of such coverage has been phenomenal. In 1940, only 12 million Americans held private health insurance. Today, over 172 million (including 12 million with coverage supplementing Medicare), according to our estimates, are insured. And more than three-fourths of these insureds are covered under group plans.

Some 150 million have coverage for catastrophic health care costs either through insurance company major medical policies, high level basic policies, or through other plans. And such coverage continues to expand rapidly.

We recognize the need to continue closing the gap between those now insured and the total civilian population and to accelerate the purchase of comprehensive preventive, therapeutic and rehabilitative insurance benefits based upon Federal standards.

We also recognize the need to encourage the development of a system of health care which would provide accessibility to comprehensive protection to all, including the poor, near poor, and those previously uninsurable for health reasons.

Private health insurers, based upon the continued competition among insurance companies, Blue Cross-Blue Shield, and prepayment group practice plans assure the public of the opportunity to select plans on the basis of their relative administrative costs and the level of services received. There is evidence available which bears on the expected relative administrative costs of a health insurance program administered by the government and by the private sector.

Generally speaking, the larger the size of the group and the larger the size of the average claim the lower the administrative expense ratio. On this basis, the Medicare program, whose $10.7 billion claim volume in fiscal year 1974 was far in excess of that of any private program, should have a lower administrative expense ratio. According to the Department of Health, Education, and Welfare, the Medicare expense ratio is about 6 percent—of which 3.9 percent is incurred by the fiscal intermediaries and carriers and 2.1 percent by the SSA itself. Contrast this with the 3.3 percent administrative expense ratio of the privately-run Federal Employees Indemnity Benefit Plan which had an annual claim volume of about $200 million in calendar year 1973. The average administrative expense ratio for all size groups insured by private companies is only about 8 percent. These ratios are exclusive of State premium taxes and risk charges. A recently completed governmental study further confirms these findings.

Some people assert that private insurance companies make exorbitant profits. The actual fact is that profits of private health insurance companies during the last six years, while varying from company to company, have averaged less than 1 percent of premiums.

The need for accountability

The public is entitled to expect the federal government to subject private insurance carriers to a high degree of accountability. Along with having a high level of benefits available, carrier operations, in connection with the provision of such benefits, must be appropriately supervised.

In addition, the public is entitled to the assurance that the care received meets professional standards of quality, is medically necessary, and is delivered at a cost level which is not unnecessarily inflated by wasteful practices.

To achieve these results, we proposed that any universal health insurance program incorporate the following types of controls.

1. A system under which hospitals and other institutions establish rates in advance on a non-discriminatory basis with federal guidelines and with review by representatives of the public and private sectors. Experience with this type of arrangement, although limited, shows real opportunities for reduction in the rate

of escalation in hospital costs. It provides to the well-run institution adequate financing to maintain and expand its services to the community.

2. Reimbursement for non-institutional providers should be based on the concept of "usual and customary" fees, administered in accordance with prevailing fee guidelines. The rate of escalation allowable should be consistent with criteria drawn from comparable measurements in the Consumer Price Index.

3. The quality of care and necessity of services to be rendered should be subject to a monitoring and evaluation system, such as the PSRO program now being implemented for Medicare and Medicaid patients. This should be expanded to cover all patients. This type of quality care evaluation should also be extended into the ambulatory care area. Such a program is essential to provide reasonable restraints on the increased demands for care.

4. Planning—Our health care resources are a national asset which must be intelligently managed if we are to get the best use out of present facilities and services, and encourage expansion on a basis which eliminates unnecessary duplication and wasteful use of manpower. The recently enacted National Health Planning and Resources Development Act of 1974 provides for broad-based community involvement in the determination of health care needs and priorities as the initial step in a coordinated strategy which encompasses local, State, and Federal agencies. The planning process will be effective only if the principles of the Act are promptly and aggressively implemented.

Representatives of the insurance industry are alreay involved in all of these processes. In particular, we are already heavily represented on the advisory councils, boards, and committees of areawide and Statewide planning agencies, a role we would expect to continue as the new legislation is implemented. Any national health insurance plan should continue to draw upon this expertise and experience.

Experience has demonstrated that with the enactment of legislation providing comprehensive health insurance benefits, there is a marked increase in the use of care. Thus, the long-range costs will be influenced by the ability to manage the increased demand so that there is improved access to care for necessary services while discouraging unnecessary services and unjustified price increases. The ineffectiveness of government alone in coming to grips with this issue is demonstrated by the following experiences:

1. In Sweden, with its system of government control and financing health care expenditures increased by 614 per cent during the period 1950–66, while the increase was 174 percent in the United States.

2. Under the compulsory insurance program in Canada, there is and has been a significantly higher hospital utilization rate than in the United States, as illustrated by 1972 figures. Utilization of general hospitals was 1,518 days per 1,000 population, in contrast with 1,178 days per 1,000 population in the United States.

3. In Great Britain, increasing criticism of the National Health Service has led to the appointment of a Royal Commission to investigate charges of overused and outmoded facilities, long waits for all but emergency medical care and widespread dissatisfaction with the system on the part of both medical care providers and the public. Despite evidence of poor performance, expenditures under the National Health Service have increased 15 percent per year between 1969 and 1973, almost twice as fast as the overall price level in Great Britain.

SUMMARY AND CONCLUSION

The private health insurance business has been doing an effective and efficient job for forty years. It is a highly competitive industry which provides a valuable service at an extremely low profit. It has the know-how to continue and expand its services under a national health insurance program. It should be permitted to do so. Any national health insurance measure that receives serious Congressional attention now or in the future should place primary reliance and fully utilize the experience and proven capacities of the present system with only a judicious use of public funds and governmental authority.

The National Health Care Act of 1975, introduced in the Congress by Congressman Omar Burleson of Texas (H.R. 5990) and by Senator Thomas J. McIntyre of New Hampshire (S. 1438), contains the essential balance of public funds, governmental authority and private sector participation. It is realistic. Tax dollars are used only where they have to be spent. The Act phases in comprehensive benefits over time so that medical costs will not be pressured to new and higher levels. It balances a need for greater benefits for the poor with a realistic use of public funds and with an appropriate dependence on private insurers. It makes the private sector responsible for providing coverage for those self-supporting individuals previously deemed uninsurable. The National Health Care Act uses the present tax system to encourage compliance with Federal health benefit standards. It uses private insurers for what they can do best—to employ its know-how in plan design, marketing, actuarial, claims service, and provider relations in areas of cost and equality assurance. And it uses government for what it can do best—for oversight regulation, to set standards, to provide for orderly change, to lay the groundwork for the faster pursuit of quality health care for all at a price we can afford to pay, and to provide financing for the poor and near poor.

We appreciate this opportunity to express our views and pledge our full cooperation in the development of a national health insurance program which will be in the best interest of all Americans.

Mr. Rostenkowski. Thank you, Mr. Rathgeber.

Yesterday, in testimony before this committee, Mr. Meany mentioned that in making a statement before a committee such as this, that was no time to compromise. He had a position, and he was, at the time of making the statement, going to stay with his position.

But he said that there would be another time where he could see concessions then bargaining.

Would you be willing to make that statement, Mr. Rathgeber?

Mr. Rathgeber. Well, certainly, as we indicated in this testimony, we do not think that any bill such as has been proposed will be exactly the one that is passed, and there will have to be compromises.

For example, the benefit structure that we have suggested can be modified. It does not have to be exactly that way. It could be reduced somewhat to cut down the costs in the initial phases. That would be one area.

There are other ways of handling the tax incentives. Certainly we would be willing to discuss these things, but we think that the fundamental principles in this National Health Care Act are quite sound.

Mr. Rostenkowski. You are aware, Mr. Rathgeber, that we had before us legislation with respect to health insurance for the unemployed. How would H.R. 5990 affect unemployed persons?

Mr. Rathgeber. This provides that for two calendar months after the month of layoff that the regular coverage would be continued, so that would be automatically covered for everybody.

Then, if these people are still laid off and their incomes fall, then they would be eligible for the State plans, and the amount that they would pay would depend upon their income. But there would be a provision for covering all of the unemployed in one of those two ways so there would be continuity of coverage.

Mr. Rostenkowski. What is provided for in this legislation with respect to catastrophic coverage?

Mr. Rathgeber. Well, it is very complete coverage. There is no total limit of costs that are covered by the bill. There is this $1,000 annual limit on a family's out-of-pocket expenses. This would be for the deductibles and the coinsurance, and once the family reached that $1,000 level, and that is for the whole family, then there would be no further deductibles or coinsurance.

The $1,000 is scaled down for lower income families. It is not as high as that for them. So anything above that is completely covered, and without limit.

Mr. Rostenkowki. Thank you, sir.

Mr. Duncan will inquire.

Mr. DUNCAN. Mr. Meany yesterday also alleged that the cost of administering an insurance program would be less by the Government than it would be by private insurance carriers. What is your view of that?

Mr. RATHGEBER. Well, the only official statement we have seen is the report that was published by the General Accounting Office in the report to the House Committee on Ways and Means. Those are the only official figures that we have seen. I might just quote from page 18 of that report, where it refers to the DDR's, that is the Division of Direct Reimbursement that handles this under the Bureau of Health.

It says, "DDR's costs for 1973 were substantially higher than those of the private intermediaries we reviewed."

Later, it says, "Despite DDR's higher cost, it generally took longer than other intermediaries to pay bills and settle with providers. Its error rate was average."

This report was released on September 30, and I would like to suggest it be made part of the record.

Mr. ROSTENKOWSKI. Without objection.

[Report referred to follows:]

REPORT TO THE HOUSE COMMITTEE ON WAYS AND MEANS BY THE COMPTROLLER GENERAL OF THE UNITED STATES

PERFORMANCE OF THE SOCIAL SECURITY ADMINISTRATION COMPARED WITH THAT OF PRIVATE FISCAL INTERMEDIARIES IN DEALING WITH INSTITUTIONAL PROVIDERS OF MEDICARE SERVICES

SEPTEMBER 30, 1975.

GAO compared performance and cost of the Division of Direct Reimbursement with that of four contract intermediaries. It found that the average cost of a bill processed by the Division in 1973 was greater than that of the four private insurance companies.

Higher salaries and lower productivity appear to be major reasons for higher costs of the Division, which, unlike the private intermediaries, had no production standards. Financial reports required of private intermediaries were not required of the Division.

GAO is recommending that HEW direct social security to (1) require that the Division develop cost data and (2) evaluate its performance.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C.

B-164031(4)

HON. AL ULLMAN,
Chairman, Committee on Ways and Means,
House of Representatives.

DEAR MR. CHAIRMAN: As requested by the former Chairman in his letter dated November 1, 1973, we have reviewed the Government's performance in dealing with institutional providers of health care under Medicare, as compared with the performance of private contract intermediaries.

As agreed with the Committee staff, we are providing copies of this report to Congressman Barber B. Conable, Jr.

We want to invite your attention to the fact that this report contains recommendations to the Secretary, Department of Health, Education, and Welfare, which are set forth on pages 18 to 19. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. We will be in touch with your office in the near future to arrange for copies of this report to be sent to the Secretary and the four Committees to set in motion the requirements of section 236.

Sincerely yours,

ELMER B. STAATS,
Comptroller General of the United States.

DIGEST

The Social Security Act authorizes HEW to contract with private organizations, generally health insurance companies, to act as fiscal intermediaries for institutional providers. Providers can also choose to deal directly with the Government rather than an intermediary. These providers are serviced by the Division of Direct Reimbursement of Social Security's Bureau of Health Insurance.

GAO compared the Division's performance and cost for 1973 with that of four contract intermediaries—Mutual of Omaha, Travelers, the Maryland Blue Cross Plan, and Hospital Service Corporation (the Chicago Blue Cross Plan).

GAO found that the average cost, excluding audit, of a bill processed by the Division, was $12.39 compared to $7.31 for Travelers, $7.28 for Mutual, $3.81 for Chicago, and $3.55 for Maryland.

The Division and intermediaries like Travelers and Mutual serve providers in a number of States, thus requiring field offices, and serve a higher percentage of skilled-nursing facilities, whose bills are considered more difficult to process than hospital bills. Such intermediaries can be expected to have higher costs than Blue Cross plans, which primarily serve hospitals in only one State or part of a State.

It appears that some of the higher costs of Travelers, Mutual, and the Division result from the wide geographic dispersion of their providers. There are many States where one of the above intermediaries serves only one or two providers.

GAO believes the committee should consider amending the Social Security Act, to allow HEW to redesignate an intermediary when because of geographic dispersion, the provider's selection appears to inhibit efficient administration. (See p. 19.)

The Division of Direct Reimbursement's costs substantially exceed the costs of Mutual and Travelers. High salaries and lower productivity appear to be major reasons for the higher costs of the Division, which, unlike the private intermediaries, had no production standards.

The Division's performance was not above average. It generally took longer than the private intermediaries to pay bills and make final settlements with providers. Its error rate was about average. (See pp. 12 to 14.)

The Social Security Administration did not compare the Division's costs with those of the private intermediaries. Financial reports required of private intermediaries were not required of the Division. GAO had to develop cost data for the Division to make its comparison.

GAO recommends that HEW instruct the Social Security Administration to:

—Require the Division to develop cost data similar to the private intermediaries.

—Evaluate the Division's performance as it evaluates the private intermediaries' performance. (See pp. 18 to 19.)

HEW did not agree with the methodology GAO used to compare the Division with private intermediaries. HEW provided data to show that the Division's cost per bill has dropped substantially since 1973. GAO has not verified this data. (See p. 22.)

CHAPTER 1.—INTRODUCTION

In a November 1, 1973, letter, the Chairman, House Committee on Ways and Means, asked us to compare the performance of the Government (specifically, the Division of Direct Reimbursement (DDR), Bureau of Health Insurance (BHI), Social Security Administration (SSA) with that of selected private contract intermediaries in dealing directly with institutional providers of Medicare health care. DDR functions as an intermediary for providers choosing to deal directly with the Government. (See app. I.)

We were asked to compare:

—workloads,

—operational costs,

—quantitative performance data, such as error rates and bill processing time,

—bill processing systems,

—production standards,
—staffing and salary levels, and
—audit and cost report settlement activities.

THE STATUTORY AUTHORITY

Title XVIII of the Social Security Act (42 U.S.C. 1395), enacted July 30, 1965, established the Medicare program to help protect elderly persons from the high costs of health-care services.

The Medicare program, which became effective on July 1, 1966, is administered by SSA, Department of Health, Education, and Welfare (HEW), and provides two basic forms of protection for eligible persons, generally age 65 and over:

—Part A, hospital insurance benefits, generally financed by special social security taxes, covers inpatient hospital services and certain postrelease care in skilled-nursing facilities and patients' homes.
—Part B, supplementary medical insurance benefits, is a voluntary program, financed by premiums and Federal contributions, covering physician services and a number of other medical and health benefits.

Organizations called intermediaries handle part A benefits and organizations called carriers handle part B benefits. This report deals with intermediary organizations.

FUNCTIONS OF INTERMEDIARIES

Section 1816(a) of the Social Security Act authorizes HEW to contract with various private organizations nominated by providers to intermediate in administering Medicare benefits.

Intermediaries' responsibilities include:

—paying providers at least monthly, on an estimated-cost basis, for covered services;
—consulting with providers to develop accounting procedures to insure that providers receive equitable payment under Medicare;
—serving as a communication conduit between HEW and providers;
—making necessary audits of providers' records to insure proper payment; and
—making final annual determinations of the amounts payable to or receivable from the providers.

Intermediaries are reimbursed for administrative costs incurred in performing these functions. In 1973, intermediaries' administrative costs to Medicare, including DDR, were about $134 million. During this period, intermediaries processed about 20.2 million bills and paid benefits totaling about $7.4 billion.

As of September 30, 1973, SSA had contracted with 10 organizations to act as intermediaries for 6,577 hospitals, 3,879 skilled-nursing facilities, and 1,880 home health agencies. One of these organizations, the Blue Cross Association, has subcontracted with 73 Blue Cross plans throughout the United States.

In addition, 184 hospitals, 83 skilled-nursing facilities, and 343 home health agencies had elected to deal directly with SSA. These organizations, located in 38 States, the District of Columbia, and Puerto Rico, are served by DDR.

The number of hospitals, skilled-nursing facilities, and home health agencies serviced by the various intermediaries is summarized in appendix II.

BASIS FOR SELECTING INTERMEDIARIES FOR REVIEW

In selecting intermediaries for our review, the Chairman asked us to consider (1) the type of providers serviced, (2) the geographic dispersion of those providers, and (3) the type of workload.

We selected Mutual of Omaha Insurance Company (Mutual), Travelers Insurance Company (Travelers), Maryland Blue Cross plan (Maryland), and Hospital Service Corporation—the Chicago Blue Cross plan (Chicago). Mutual served providers in 24 States and the District of Columbia, and Travelers served providers in 18 States. Providers served by Mutual and Travelers included many skilled-nursing facilities, whose bills are considered relatively difficult to process; DDR served a large number of home health agencies, whose bills are considered relatively difficult to process.

SSA and Mutual processed bills at a centralized office. Travelers processed bills at its eight field offices.

Maryland was located about 15 miles from DDR. Chicago was the largest of all intermediaries and, like DDR was located in a medium to high wage area and served many municipal hospitals. Neither Blue Cross plan has field offices.

The 1973 administrative costs and number of bills processed for intermediaries we reviewed are shown below.

		Blue Cross plans			
	DDR	Maryland	Chicago	Mutual	Travelers
Inpatient hospital	110,001	73,358	413,629	38,836	124,002
Inpatient skilled-nursing facility	15,061	2,161	5,368	88,164	113,818
Outpatient hospital and skilled-nursing facility	[1] 313,013	214,859	547,559	53,023	128,506
Home health agency	50,332	15,164	31,359	26,454	12,373
Other	10,253	2,548		11,418	512
Total	498,660	308,090	997,915	217,895	379,211
Administrative costs	$4,600,000	$1,500,000	$5,200,000	$2,300,000	$4,700,000

[1] Includes 210,000 outpatient magnetic tape bills from New York City hospitals and 39,889 community health center bills that are similar to outpatient bills. See p. 7 [265] for a discussion of outpatient bills.

DEVELOPING COMPARATIVE COSTS

For our comparison, we classified intermediaries' administrative activities into the following four functions:

1. Bill processing includes:

—reviewing admission notices from hospitals and skilled-nursing facilities and start-of-care notices from home health agencies,

—processing queries to SSA's central records to ascertain the patient's eligibility and benefit status and transmitting SSA's responses to providers,

—reviewing bills from providers,

—batching and transmitting paid bills to SSA for recording on the patient's master beneficiary record, and

—providing liaison with provider utilization review committees and handling routine inquiries from beneficiaries or providers.

2. Provider assistance includes:

—holding workshops and meetings with providers and physicians,

—dealing with community and individual provider patterns of care,

—discussing operating policies with individual providers, and

—providing consulting services to establish and maintain provider accounting systems.

3. General admnistration and support includes:

—personnel recruitment and training,

—mailroom operations,

—disbursement and accounting,

—budget preparation, and

—general management and legal activities.

4. Provider auditing includes:

—desk reviewing and field auditing provider cost reports, including subcontracts with public accounting firms,

—establishing interim reimbursement rates, and

—recovering overpayments.

Since intermediaries did not allocate all costs the same way, adjustments were necessary for our comparisons.

INTERMEDIARY COST ALLOCATION

Private intermediaries submit costs to SSA on the quarterly Cumulative Interim Expenditure Report and Budget (SSA Form 1527) and the Final Administrative Cost Proposal (SSA Form 1615). SSA reimburses intermediaries for their Medicare administrative costs.

DDR was not required to submit quarterly and annual expenditure reports to BHI, nor had it prepared such reports for its own management purposes. Therefore, we had to develop comparable administrative cost data for DDR and for certain supporting activities provided by organizations within and without SSA.

DDR performed certain functions not performed by contract intermediaries, such as processing provider-based physician claims and servicing direct-dealing

Group Practice Prepayment plans. We eliminated costs of these functions from DDR's administrative costs. DDR personnel also were involved in special projects, and where identified, these costs were eliminated.

DDR used services of other organizations, such as SSA's Bureau of Data Processing, HEW regional offices, and, for disbursements, the U.S. Treasury. To be comparable with contract intermediaries, costs of such services were added to DDR costs. An analysis of how we developed DDR's total administrative costs appears in appendix III.

For contract intermediaries, we verified the accuracy and consistency of administrative costs reported to SSA.

CHAPTER 2.—INTERMEDIARY COSTS

SSA has used the cost per bill processed to show performance in its intermediary administrative costs reports. Although provider audit cost has not been measured in relation to bills processed because this cost is incurred long after the related bills have been paid, we have included such costs to provide an overall picture. The intermediaries' cost per bill processed in 1973 is shown below. (See app. IX for SSA comments regarding fiscal year 1975 costs.)

Function	DDR[1]	Blue Cross plans		Mutual	Travelers
		Maryland	Chicago		
Bill processing	$4.24	$1.98	$2.11	$3.37	$4.56
Provider assistance	1.27	.09	.51	2.17	.62
General/administrative	1.73	1.17	.88	1.74	2.13
Blue Cross Association costs[2]		.31	.31		
Total excluding audit	7.24	3.55	3.81	7.28	7.31
Audit	1.99	1.39	1.32	3.16	5.02
Total, including audit	9.23	4.94	5.13	10.44	12.33

[1] Includes New York City municipal hospitals' outpatient bills, which are not processed by DDR. (See discussion below.)

[2] The Blue Cross Association is reimbursed by the Government for the administrative costs of supervising its subcontractor plans and for certain operational costs connected with medicare. These administrative costs, which amounted to $0.31 per bill in 1973, have been added to the plans' costs for purpose of comparison.

In comparing costs, it should be noted that SSA has arranged with the New York City municipal hospitals, serviced by DDR, to submit their outpatient bills on magnetic tape directly to SSA's Bureau of Data Processing. DDR does not process these outpatient bills. Eliminating these bills (about 210,000 in 1973—or about 42 percent of DDR's claimed workload) and related costs of about $32,000 incurred by SSA for processing such bills and by SSA's New York regional office for following up on exceptions, would substantially change DDR's cost per bill processed. The following table shows the 1973 cost per bill processed with SSA's magnetic tape bills excluded, and is a more valid comparison.

Function	DDR	Blue Cross plans		Mutual	Travelers
		Maryland	Chicago		
Bill processing	$7.21	$1.98	$2.11	$3.37	$4.56
Provider assistance	2.20	.09	.51	2.17	.62
General/administrative	2.98	1.17	.88	1.74	2.13
Blue Cross Association costs		.31	.31		
Total, excluding audit	12.39	3.55	3.81	7.28	7.31
Audit	3.44	1.39	1.32	3.16	5.02
Total, including audit	15.83	4.94	5.13	10.44	12.33

The national average cost, excluding audit, per bill processed for private intermediaries was $6.45.

Intermediary officials and SSA generally agreed that certain types of bills are more difficult to process than others. SSA says it has attempted for several years to develop weighting factors to use in comparing and evaluating intermediary performance but has not done so primarily because of insufficient staff.

Both Mutual and Travelers had developed weighting factors by bill-type and Travelers was using its factors for measuring and comparing the productivity and performance of its eight field offices. Travelers weights ranged from 1.00 for an outpatient bill to 3.35 for an inpatient, skilled-nursing-facility bill.

The adjusted unit cost—excluding provider audit costs—giving recognition to Traveler's weighting factors, was $5.07 for DDR; $2.67 for Maryland; $2.25 for Chicago; $3.18 for Mutual; and $3.50 for Travelers. By eliminating SSA's magnetic tape bills and related costs, however, DDR's adjusted unit cost would be $7.13.

We do not know if Traveler's weighting factors accurately reflect the relative difficulty of processing different types of bills. However, they do represent a formal recognition of these differences.

To further analyze differences between intermediary costs, we examined personnel compensation and bills-processed per man-year in detail.

PERSONNEL COMPENSATION

Personnel costs account for about 65 percent of an intermediary's expenses. Our comparison of average annual salaries for personnel performing similar jobs as of December 31, 1973, showed that DDR personnel were consistently higher paid than personnel in comparable jobs with the four private intermediaries. A comparison of personnel that charge most or all of their time to the intermediary function is included in appendix IV.

Comparisons of annual compensation for three jobs representing large portions of total personnel costs—registered nurses, claims examiners, and accountants and auditors—are shown in the following table. Annual compensation includes the value of fringe benefits such as health insurance, retirement, and life insurance. We have also included comparability adjustments for DDR's higher vacation and sick leave benefits which, except for Mutual, are generally offset by the private intermediaries' shorter workweek.

ANNUAL COMPENSATION FOR SELECTED POSITIONS

Intermediary	Accountants and auditors	Claims examiners	Registered nurses
DDR	$21,600	$11,600	$13,600
Maryland	17,300	7,700	12,900
Chicago	18,600	9,800	12,600
Mutual	13,700	7,200	10,000
Travelers	13,800	7,000	11,400
Average (unweighted) of the 4 private intermediaries	15,900	7,900	11,700

DDR's annual compensation exceeded the average annual compensation of the four private intermediaries by 36 percent for accountants and auditors, 47 percent for claims examiners, and 16 percent for registered nurses.

DDR's annual compensation exceeded Maryland's annual compensation by 25 percent for accountants and auditors, 51 percent for claims examiners, and 5 percent for registered nurses, although DDR and Maryland are about 15 miles apart and compete in the same job market.

BILLS PROCESSED PER MAN-YEAR

The most meaningful measure of employee productivity in processing bills is the number of bills processed per productive man-year. SSA has developed a standard formula for use by its contract intermediaries in computing the number of available productive man-years—excluding provider audit functions.

The following table shows number of bills processed per productive man-year by intermediary.

Intermediary:	*Number of bills processed*
DDR[1]	1,456
Travelers	1,762
Mutual	1,944
Maryland	4,197
Chicago	4,204

[1] Does not include magnetic tape bills discussed on page 7 [265].

As mentioned before, there are differences in the relative difficulty of types of bills processed. Also, because of differences in amounts of annual and sick leave, break time, and hours worked per week, the number of productive hours in a man-year varies among intermediaries.

After making adjustments for Travelers' weighting factors and providing comparability in the number of productive hours in a year, we computed the adjusted bills processed per man-year as shown below.

Intermediary:	*Number of bills processed*
DDR	2,500
Travelers	3,900
Mutual	4,200
Maryland	5,700
Chicago	6,600

Although adjustments result in differences in number of bills processed per man-year, they do not change the intermediaries' rankings.

Each private intermediary has some types of production standards or goals to measure employee performance. DDR had no such standards.

OTHER FACTORS AFFECTING COST

In addition to salaries, productivity, and differences in the relative difficulty of types of bills, an intermediary's costs are affected by its type of organization, the number of bills per provider, and the location of its providers. For example, in its 1972 performance evaluation of Mutual, the Bureau of Health Insurance noted that Mutual must maintain field offices to service its providers across the country, whereas most intermediaries operate from a central location in only one State or part of a State. These field offices would result in higher costs for such items as travel and communication.

CHAPTER 3.—INTERMEDIATE PERFORMANCE

Intermediaries deal with providers in three areas—bill processing, provider assistance, and provider auditing and settlement. These areas encompass three of the four intermediary activities. The fourth activity, general administration and support, involves the overall management necessary to carry out the other three functions.

This chapter discusses the activities and compares the performance of intermediaries in the three areas mentioned above. While many objective standards are used to evaluate bill processing, there are no established standards for evaluating provider assistance or audits and settlements.

BILL PROCESSING

The intermediaries' bill processing systems consist of (1) determining eligibility for Medicare benefits and (2) processing for payment bills submitted by providers for services rendered to eligible beneficiaries.

Chicago processed home health agency and skilled-nursing facility bills manually, but had a partially automated system for hospital bills. The other four intermediaries processed all bills manually, except for Maryland which automated its outpatient and inpatient bill processing systems beginning March and July 1973, respectively. All five used automated systems to compile data and transmit and receive information from SSA on beneficiary eligibility.

Except at DDR, claims examiners did not process bills through the system; they specialized by function (such as updating the report of eligibility or verifying charges) or by the type of bill. For example, registered nurses reviewed bills from home health agencies and skilled-nursing facilities. DDR's examiners were responsible for the bill from time of receipt until approval for payment.

PERFORMANCE INDICATORS

Various statistical measurements, such as weeks of work on hand and number of errors in bills, are used to evaluate intermediary performance. Performanace measures are affected by type of providers served, number of bills received, and processing procedures used by the intermediary.

Intermediaries report their production to SSA in a monthly workload report. Many statistics are based on inventories of bills at the end of each month, and supporting documentation is generally maintained for less than 6 months. Therefore, to verify some figures, we reviewed only 1 to 3 months' documentation for 1973 or 1974.

We found minor discrepancies due to errors in inventory procedures. However, the discrepancies did not have a significant effect on our comparisons.

WEEKS OF WORK ON HAND

The national average for all intermediaries for 1973 was 1.4 weeks of work on hand. The weeks of work on hand for intermediaries reviewed at the end of 4 selected months in 1973 is shown below.

Intermediary	March	June	September	December
DDR	3.4	3.2	3.4	5.0
Maryland	.8	.8	1.2	1.3
Chicago	.8	1.0	1.5	2.4
Mutual	.7	.6	1.0	1.6
Travelers	.8	.7	.6	.7

BILLS PENDING OVER 30 DAYS

At the end of four selected months in 1973, intermediaries had the following percent of bills pending over 30 days.

Intermediary	March	June	September	December
DDR	12.1	12.1	18.1	26.8
Maryland	19.1	32.4	13.0	32.3
Chicago	14.9	20.3	19.5	18.9
Mutual	16.4	13.8	12.6	11.7
Travelers	11.0	19.1	18.8	12.2

BILL PROCESSING TIME

Bill processing time is measured from receipt of the bill until the check is written. Because some types of bills are more difficult or involve different processing steps, processing time varies.

Intermediaries generally process four types of bills—inpatient hospital, inpatient skilled-nursing facility, outpatient hospital and skilled-nursing facility, and home health agency.

We computed the percentages of bill types paid within certain time periods, based on a random sample of bills paid during 1973. This information is shown below.

Type of bill	Percentage of bills paid				
	DDR	Maryland	Chicago	Mutual	Travelers
Inpatient hospital paid within (days):					
15	46	79	89	86	86
30	85	93	96	94	94
45	94	98	97	99	97
60	96	99	98	100	99
Inpatient skilled-nursing facility paid within (days):					
15	7	28	29	77	83
30	50	69	57	92	96
45	73	81	75	94	99
60	83	87	83	99	99
Home health agency paid within (days):					
15	28	34	3	92	67
30	66	73	23	99	93
45	78	84	48	99	98
60	84	91	75	99	100
Outpatient hospital and skilled-nursing facility paid within (days):					
15	47	67	61	66	57
30	77	97	88	96	87
45	90	98	94	98	94
60	97	99	96	100	98

DDR said that the New York City and State and Puerto Rican Government hospital bills were extremely difficult to process. Therefore, we eliminated these bills to see how their absence affected bill processing time. Without them the percentage of bills paid increased from 46 to 54 within the 15-day range.

ERRORS IN HEALTH INSURANCE BILLS

SSA reviews bills from intermediaries twice to determine if information on the bill (1) is consistent and (2) agrees with eligibility and utilization data in the health insurance master beneficiary record at SSA headquarters.

SSA sends quarterly reports to intermediaries showing the number of erroneous bills.

For 1973, the percentage of bills returned for errors was 3.1 for DDR, 1.3 and 2.2 for Maryland and Chicago respectively, 3.3 for Mutual, and 3.9 for Travelers.

PROVIDER ASSISTANCE

DDR uses its headquarters' staff and direct-dealing specialists from each of SSA's 10 regional offices for provider assistance. Chicago and Maryland serve relatively small geographic areas and have no field offices. Mutual has a field operations section which includes staff at five field locations to handle provider assistance. Travelers furnishes provider assistance from eight field offices.

Intermediaries have different criteria for provider visits. Maryland, Chicago, and DDR said that they visit providers as needed.

Mutual has an annual goal for visits to each type of health provider. For a skilled-nursing facility, Mutual's goal is a yearly review by a field representative and a nurse; for a hospital, its goal is four reviews a year by a field representative; and for a home health agency, its goal is three or four visits a year, generally by a nurse.

Travelers' personnel are required to visit providers at least once a year to perform a utilization review and a Medicare audit and to attend a utlization review committee meeting. Hospitals are visited at least three times each year. Skilled-nursing facility visits are based on the number of approved admissions.

In 1973, private intermediaries visited providers as follows: Maryland—234, Chicago—3,645, Mutual—2,500, and Travelers—2,026.

DDR did not record the total number of visits to providers. DDR said that SSA's regional offices did not have a significant role in provider relations. This matter is discussed below.

ASSISTANCE TO DIRECT-DEALING PROVIDERS BY SSA REGIONAL PERSONNEL

In computing DDR's costs, we included about $438,000, BHI's estimate of the regional office costs associated with direct-dealing activities.

By an August 1, 1974, letter, the director of DDR, said that he took exception to our inclusion of certain regional office salaries and benefits as part of DDR's administrative costs because we did not allocate similar regional office costs to the private intermediaries. The director's main point was that most provider assistance activities for direct-dealing providers were handled by DDR personnel at SSA headquarters.

We did not include similar costs for other intermediaries because regional offices do not provide them with a similar service. BHI instructions state that each regional office is the primary resource and contact point for direct-dealing providers and, therefore, should have at least one person designated to handle direct-dealing activities.

We reviewed operations of the New York and Chicago regional offices relating to direct-dealing activities. The New York office had a reimbursement branch which handled direct-dealing activities. In 1973, the New York office made 291 visits to direct-dealing providers, State agencies, the New York City Health and Hospitals Corporation, and other organizations involved with Medicare. The Chicago office made 124 visits to 82 providers.

We used BHI's 1973 budget estimate of 20 man-years for direct-dealing activities for its 10 regional offices to compute DDR's costs. The New York and Chicago offices were allocated 5.3 and 2.7 man-years, respectively; they incurred 8.9 and 3.2 man-years, respectively, in 1973 in implementing their direct-dealing responsibilities. Since actual man-years for the two regional offices were about 50 percent more than budgeted man-years, we believe we are being reasonable in attributing SSA regional office costs of about $438,000 to DDR's activities.

COST REPORT AUDIT AND SETTLEMENT ACTIVITY

Providers are paid during the year at interim rates. At the end of its fiscal year, each provider submits a cost report and settlement is made based on its costs.

SSA instructions require that cost reports be submitted to intermediaries within 90 days after the end of the provider's accounting period. Before final settlement, a desk review, including a cost analysis and a review of the intermediary's past experience with the provider, is made of the cost reports. Final settlement may be made after the desk review. When the provider is scheduled for field audit, intermediaries make a tentative settlement based on the desk review. The results of the desk review determine when a field audit is to be made.

After deciding to perform a field audit, the intermediary determines whether it should be of full or partial scope. Intermediaries generally require a full-scope audit for a first-year cost report or when there has been a change of ownership. However, most audits are partial, designed to investigate areas of concern identified during the comprehensive desk audit.

The percent of cost reports for the 2-year period ending June 30, 1973, settled without audit as of December 31, 1973, was 11 for Maryland, 17 for Chicago, 30 for DDR, 59 for Mutual, and 62 for Travelers.

There were lengthy delays in the various steps of the settlement process during the program's first several years. Later audits and settlement activity partially involved reduicng backlogs of earlier years' unaudited and unsettled reports.

In 1973, cost reports settled by the five intermediaries exceeded cost reports due by 13 to 38 percent, indicating progress in reducing the backlog.

The percent of cost reports received and settled as of December 31, 1973, is shown below.

Intermediary	Cost reports due from program inception through June 30, 1971		Cost reports due from June 30, 1971 through June 30, 1973	
	Percent received	Percent received reports settled	Percent received	Percent received reports settled
DDR	94	67	88	44
Maryland	92	87	82	69
Chicago	99	97	97	92
Mutual	99	93	99	84
Travelers	99	96	98	90

CHAPTER 4.—CONCLUSIONS, RECOMMENDATIONS, AND MATTER FOR CONSIDERATION BY THE COMMITTEE

CONCLUSIONS

DDR's costs for 1973 were substantially higher than those of the private intermediaries we reviewed. The average cost, excluding audit, per bill processed by DDR was $12.39, compared with $7.31 for Travelers, $7.28 for Mutual, $3.81 for Chicago, and $3.55 for Maryland.

Intermediaries similar to DDR, serving (1) providers in a number of States and thus requiring field offices, and (2) a higher percentage of skilled-nursing facilities, have higher costs than Blue Cross plans, which generally serve providers (mostly hospitals) in only one State or part of a State. However, DDR's costs substantially exceed Mutual's and Travelers', whose operations are more similar to DDR's.

The higher salaries and lower productivity of DDR employees appear to be major reasons for DDR's higher costs. DDR was the only intermediary reviewed that did not have employee production standards.

Despite DDR's higher costs, it generally took longer than other intermediaries to pay bills and settle with providers. Its error rate was average.

SSA did not compare DDR's costs with the costs of private intermediates. Financial reports required of private intermediaries were not required of DDR. We had to develop cost data for DDR's intermediary functions.

RECOMMENDATIONS

We recommend that the Secretary, HEW, instruct SSA to:

—Require DDR to develop and report all relevant costs, including regional office costs, for performing intermediary functions, so that SSA can evaluate DDR's cost effectiveness.

—Continuously evaluate DDR's performance as it does private contract intermedaries.

—Develop weighting factors which recognize the relative difficulty in processing different types of bills, to permit better evaluation of intermediary performance.

MATTER FOR CONSIDERATION BY THE COMMITTEE

Section 1816 of the Social Security Act permits providers to select their intermediaries. As a result, no intermediary has an exclusive territory, as do the carriers who handle part B Medicare benefits. It is rare for one intermediary to handle all part A providers in a State.

Some of the higher costs of Travelers, Mutual, and DDR apparently result from the wide geographic dispersion of providers, resulting in the need for field offices and distant travel. There are many States where one of the above intermediaries serves only one or two providers.

The Committee should consider amending the Social Security Act to authorize the Secretary, HEW, to redesignate an intermediary when the provider's selection impedes efficient administration because of the small number of providers in the provider's geographical area that are served by the selected intermediary.

AGENCY AND INTERMEDIARY COMMENTS

HEW did not agree with the methodolgy we used to compare DDR with the private intermediaries.

It noted that in determining DDR's unit cost, we excluded magnetic tape bills on the grounds they are not processed by DDR, even though (1) the costs analyzed include claims examination, cost auditing, and professional relations and (2) automated bills processed by intermediaries are included in determining their unit costs.

Two intermediaries included in our comparisons used automated bill processing to some extent. However, both received bills on standard billing forms and converted the data into a format compatible with their automated processes. DDR's magnetic tape bills were prepared by the provider and received and processed by SSA's Bureau of Data Processing. DDR does not consider such bills as workload in determining its bill-processing staff requirements. DDR estimated that it spent about one-fourth of a man-year on work directly related to processing these 210,000 bills. Our computation of unit cost which excludes magnetic tape bills also excludes the processing costs related to these bills.

As noted on page 16 [269], the actual time spent by the New York region on direct-dealing activities was substantially more than was included in our cost estimates. We believe the understatement of such costs more than offsets any cost that could be attributed to professional relations regarding the magnetic tape bills.

Our detemination of audit cost was not adjusted to eliminate the cost attributable to magnetic tape outpatient bills because audits involve providers' total activity. The providers submitting magnetic tape outpatient bills are also inpatient hospitals, and in some instances, skilled-nursing facilities. It would not be possible to determine the audit cost related solely to magnetic tape bills.

Our report shows DDR's costs per bill both with and without the magnetic tape bills, and audit costs are shown separately. We found that higher salaries and lower productivity were major reasons for DDR's higher costs. The salary data is based on salaries paid for comparable positions and is irrelevant to the volume of bills processed. Productivity data does not include the audit function. Therefore, any time spent on provider audit related to magnetic tape outpatient bills would not affect those figures.

HEW objected to our use of the Travelers' weighting factor. While our report shows the cost per bill and productivity per man-year using Travelers' weighting formula, we state that we do not know if it accurately reflects the relative difficulty of processing different types of bills. Our report recommends that SSA develop weighting factors to permit a better evaluation of intermediary performance. HEW noted that efforts to develop a methodology capable of weighting bill mix and the many other factors that complicate comparative evaluation will be continued.

According to HEW, we included costs incurred by the regional offices in assisting DDR but did not include these costs associated with the intermediaries. The SSA regional office costs we attributed to DDR are for provider-relations activities of regional office personnel. The private intermediaries do not use SSA regional office personnel for provider relations.

HEW stated that we did not go beyond budget estimates in determining the cost of DDR's nonintermediary functions and in allocating the costs of other Government components to DDR. Our estimates of such costs were obtained from SSA officials including those of BHI and DDR. These were based on estimated time spent and actual time charges and services used. To our knowledge, these estimates represent the best data available, and HEW has neither challenged the cost figures nor suggested a better methodology.

HEW said we failed to address the qualitative factors in intermediary operations; we addressed only the mechanical handling of bills and no aspect of quality in claims processing or other intermediary or DDR operations. The Blue Cross Association (see app. V) also noted that our report concentrated on quantitative aspects of operations.

While our report only addresses quality in terms of errors in bills, BHI addresses other quality factors in its evaluations of private contract intermediaries. As of August 1975, annual contractor evaluation reports had been issued for Travelers, covering 1973, and for Chicago, covering the first 9 months of 1973. The most current reports for Maryland and Mutual covered 1972.

The reports for 1972 did not use uniform rating terminology and in some instances did not rate specific performance areas. These reports did give overall ratings, and both Mutual and Maryland received overall ratings of satisfactory.

The reports for 1973 did not provide overall performance ratings. Instead, ratings were provided for each of eight operating areas: bill processing, provider reimbursement, provider cost-report settlement process, provider appeals procedures, utilization review, beneficiary activities, administrative management, and fiscal management. Each area was supposed to be rated as satisfactory, adequate but needs improvement, or unsatisfactory.

Chicago was rated "satisfactory" in all areas except beneficiary activities, which was rated as "adequate but needs improvement." Travelers was rated "satisfactory" in all areas except utilization review, which was rated as adequate but needs improvement," and administrative management, which was rated as "adequate, requiring substantial improvement."

Thus, it appears that the private contract intermediaries discussed in this report are generally fulfilling their Medicare responsibilities satisfactorily. While HEW stated that we did not address quality, it did not provide any information on the quality of DDR's performance.

On September 16, 1975, SSA provided fiscal year 1975 cost data for DDR and the private intermediaries. (See app. IX.) We have not verified this data.

According to SSA, DDR processed 1,097,362 intermediary bills in fiscal year 1975 including 443,286 magnetic tape bills. DDR's total costs for the intermediary function were $6,242,472, including $1,737,425 for audit. DDR's cost per bill for fiscal year 1975 was $5.69 including audit and $4.11 excluding audit, compared with calendar year 1973 costs of $9.23 and $7.24, respectively. Excluding the magnetic tape bills, DDR's cost per bill for fiscal year 1975 was about $9.40 including audit and about $6.80 excluding audit, compared with $15.83 and $12.39, respectively, for calendar year 1973.

According to SSA, the intermediaries' fiscal year 1975 costs, including audit, were: Travelers—$9.41; Mutual—$7.80; Chicago—$4.62; and Maryland—$4.57 per bill. Without audit, the per bill costs were $6.98 for Travelers, $5.87 for Mutual, $3.72 for Chicago, and $3.76 for Maryland.

DDR's bills processed, excluding magnetic tape bills, increased from 288,660 in calendar year 1973 to 654,076 in fiscal year 1975—an increase of 365,416. About 64 percent of this increase is due to Community Health Center bills, which increased from 39,889 in calendar year 1973 to 275,053 in fiscal year 1975. SSA records show that these bills require less processing time than other types of bills.

Also, because of problems in automating its bill processing in fiscal year 1974, DDR's fiscal year 1975 workload included an unusually high number of the preceding year's bills. DDR processed about 45,000 more bills than it receved in fiscal year 1975.

According to the Blue Cross Association, the Secretary of HEW already has area. We do not agree with this position. If the Secretary determines that it is the power to redesignate an intermediary when efficient administration is impeded because the intermediary selected serves few providers in the geographical inconsistent with efficient administration of the program for intermediaries to serve small numbers of providers within a given geographical area, he will have substantial difficulty proving, in the hearing required by section 1816(e) of the Social Security Act, that the arrangement is disadvantageous so that the relationship can be terminated.

Moreover, even assuming the Secretary has this authority, he cannot designate a substitute intermediary. Rather, he must service the providers directly until a group or association of providers nominate, and he approves, an acceptable substitute intermediary. He has no authority at the present time to require providers to deal with any particular organization.

Travelers (see app. VI) concurred with our report as far as it concerned that company.

Mutual (see app. VII) said that its fiscal year 1975 cost per bill was $8.24—a decrease from its cost per bill of $10.44 for 1973. Mutual attributed this cost reduction in large part to an increase in the number of hospitals serviced whose bills are considered easier to process than skilled-nursing facility or home health agency bills.

APPENDIX I

COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, D.C., November 1, 1973.

Hon. ELMER B. STAATS,
Comptroller General of the United States,
Washington, D.C.

DEAR MR. STAATS: Among the information which will be helpful in considering the various national health insurance plans, as well as evaluation of medicare operations as such, the Committee on Ways and Means is interested in obtaining data about the performance of the Federal Government in dealing directly with institutional providers of health care compared with the performance of fiscal intermediaries.

As you know, the major program which the Federal Government is involved in dealing directly with health care institutions, such as hospitals and skilled nursing homes, is under the medicare program. The Division of Direct Reimbursement of the Social Security Administration serves as the fiscal intermediary for about 650 institutions, or about 3 percent of the institutions providing health services under the medicare program. The remaining institutions deal with other organizations acting in the capacity of intermediaries, such as Blue Cross and commercial insurance companies. These organizations are under contract with the Social Security Administration to function as fiscal intermediaries under the medicare program.

Therefore, I am asking the Government Accounting Office to make a comparative analysis of the performance of the Division of Direct Reimbursement in the Social Security Administration and selected contract intermediaries including, but not necessarily limited to, the following elements:

Compare the workload and operational cost of the Division of Direct Reimbursement against selected contract intermediaries. In selecting these intermediaries, consider (1) the type of providers services, (2) geographic dispersion of those providers, and (3) the type of workload.

Analyze a sample of quantitative data that indicates performance characteristics such as: (1) error rates in bills, (2) bill processing time and workload inventories, (3) rate of denial and reversals upon reconsideration, (4) workload data, including production per many-year, (5) bill processing costs including ratio of administrative expense to benefit payments and unit cost per bill, and (6) staffing levels, including salary data.

In addition, analyze the cost report activity to determine the number of cost reports (1) due but not received, (2) received, (3) audited and not audited, (4) that have been settled, and (5) that have not been settled. Finally, for each intermediary included in the review, as well as the Division of Direct Reimbursement, a description of its bill processing system, including production standards, and other pertinent data.

In conducting this study, we would like your office to follow your usual practices of securing advance comments from the organizations involved in the study.

Your cooperation in this matter would be greatly appreciated. Please keep me advised of developments as the study progresses.

Sincerely yours,

WILBUR D. MILLS,
Chairman.

APPENDIX II

HOSPITALS, SKILLED-NURSING FACILITIES, AND HOME HEALTH AGENCIES SERVICED BY ALL INTERMEDIARIES AS OF SEPT. 30, 1973

Intermediary	Hospitals	Skilled-nursing facilities	Home health agencies	Total
Total Blue Cross Association	6,129	2,118	1,733	9,980
Blue Cross plan, Chicago, Ill.[1]	(280)	(29)	(80)	(389)
Blue Cross plan, Towson, Md.[1]	(56)	(18)	(20)	(94)
Mutual of Omaha Insurance Co	27	661	31	719
The Travelers Insurance Co	109	559	21	689
Aetna Life and Casualty	154	360	21	535
The Prudential Insurance Co. of America	35	80	29	144
National Mutual Insurance Co	8	70	27	105
Inter-County Hospitalization Plan, Inc	51	13	7	71
Hawaii Medical Service	26	14	6	46
Kaiser Foundation Health Plan, Inc	23	3	3	29
Cooperative de Seguros de Vida de Puerto Rico	15	1	2	18
Private intermediary total	6,577	3,879	1,880	12,336
DDR	184	83	[2] 343	[2] 610
Total	6,761	3,962	2,223	12,946

[1] Numbers in parentheses are included in Blue Cross Association totals.

[2] About 300 home health agencies in 4 States go through State offices and file consolidated cost reports. Therefore, DDR's total workload for the provider audit and settlement function is about 320 providers.

APPENDIX III

DDR's administrative costs as a direct-dealing intermediary during 1973 (excluding nonintermediary functions)

Administrative costs: Total DDR salaries and benefits	$3, 319, 300
Add:	
SSA central office and Treasury support costs	649, 300
Regional office costs (intermediary function only)	438, 000
Contracts with public accounting firms	358, 400
Computer costs (intermediary function only) (Bureau of Data Processing)	300, 700
Travel	59, 000
Physician consultant fees	39, 300
Non-DDR costs relating to comprehensive health centers	38, 800
Subtotal	1, 883, 500
Less:	
Estimated DDR cost for processing hospital-based physician bills and for other nonintermediary functions	447, 700
Estimated space and central office support costs for nonintermediary functions	79, 000
Estimated costs for servicing direct-dealing group practice prepayment plans	53, 500
Estimated contracts with public accounting firms for auditing group practice prepayment plans	20, 700
Subtotal	600, 900
Total	1, 282, 600
Grand total	4, 601, 900
Audit costs:	
Salaries and benefits for DDR's accounting and negotiations branch	812, 600
Contracting with public accounting firms (net of contracts for auditing group practice prepayment plans)	337, 700
Costs for comprehensive health centers	77, 600
Travel	26, 600
Postage	6, 100
Subtotal	1, 260, 600
Less:	
Estimated costs for nonintermediary functions	141, 100
Estimated costs for provider relations functions	128, 000
Subtotal	991, 500
Total administrative cost excluding audit	3, 610, 400

APPENDIX IV

STAFFING AND SALARY DATA FOR COMPARABLE POSITIONS BY INTERMEDIARY AS OF DEC. 31, 1973

Job title	DDR		Blue Cross plans				Mutual		Travelers	
			Maryland		Chicago					
	Number of persons	Salary	Number of persons	Salary	Number of persons	Salary	Number of persons	Salary	Number of persons	Salary
Fringe benefits (percent)		8.7		20.4		23.1		19.5		10.7
Administration:										
Medicare director	1	$32,000	1	$19,500	1	$26,400	1	$24,900	1	$17,000
Deputy Medicare director	1	30,100								
Supervisory medical officer	1	35,000	1	35,500			1	28,000		
Administrative assistant	1	11,000	1	13,200	1	10,100				
Bill processing:										
Claims manager	1	24,200	1	13,300	1	22,800	1	16,300		
Field office manager									8	16,200
Deputy claims manager	1	22,100	1	11,200	1	15,600	1	14,100		
Section supervisor	2	15,000			6	11,400			[1] 8	13,900
Unit supervisor	8	11,500	2	7,400	6	9,100				
Registered nurse	13	12,500	5	10,600	[2] 22	9,800	7	8,800	20	9,800
Edit clerk	10	7,500			40	6,300				
General clerk	61	7,300	5	6,500	47	4,800	28	4,700		
Keypunch operator	6	5,700	1	6,500			4	5,200		
Claims examiner	79	10,700	13	6,300	2	7,600	18	6,400	83	6,000
Reconsideration examiner	5	14,200	1	9,900	6	10,200			(1)	
Provider relations:										
Field representative	8	21,800	1	7,800	6	14,300	8	9,800	7	9,600
Registered nurse							6	10,200	3	9,800
Audit, settlement, and reimbursement:										
Accountant/auditor	34	19,900	13	14,200	84	14,500	24	12,100	36	11,900
Clerk	5	7,700	3	6,600	2	5,400				

[1] Section supervisors also act as reconsideration examiners.

[2] Registered nurses also process bills.

APPENDIX V

Blue Cross Association,
Chicago, Ill., July 25, 1975.

Mr. Gregory J. Ahart,
Director, Manpower and Welfare Division,
General Accounting Office,
Washington, D.C.

Dear Mr. Ahart: We appreciate the opportunity to review and comment on the draft report, "The Performance of the Social Security Administration in Dealing Directly with Institutional Providers of Medicare Services Compared with the Performance of Private Fiscal Intermediaries." The Maryland and Chicago Blue Cross Plans, which were a part of the study, were provided with copies of the draft report and have presented their comments to us for incorporation into this letter.

We will observe the limitations on use of the draft report, as stated on the report cover. Both involved Blue Cross Plans are also aware of and will observe the limitations.

There are several comments on the draft report which we feel may be useful in preparing the final report. First, near the bottom of page 9, reference is made to a surcharge by the Blue Cross Association to each Plan, through which the Association recovers its administrative costs. The reference is not correct in that the Association's administrative costs are not reimbursed through a surcharge on the Plans. Blue Cross Association is the Intermediary contracting with the Secretary of HEW. The Association's administrative costs, which are incurred in carrying out its performance supervision of the subcontracting Plans as well as certain operational functions including telecommunications, maintenance of an EDP system for processing Medicare claims, provider audit, financial management, etc., are reimbursed through its own budget which is directly funded by the government. However the basic point intended to be made in the draft report is correct. The Association's administrative costs are sometimes converted to a per-claim amount when comparisons are made with other Intermediaries, on a Plan by Plan basis. In such instances, the per-claim cost of the Association is added to the individual Plan's per-claim cost for purposes of the comparison. A minor language change in the draft report would serve to correct the information as to how the Association is funded.

Second, on page 11 reference is made to weighting factors used by Travelers to equate the relative difficulties in processing the several types of Medicare claims. For your information, we support the need to apply appropriate weighting factors to statistical and operational measurements of components of the Intermediary functions where such factors can be identified and applied with reasonable confidence. The Association has identified and weighted for a number of economic and operational noncontrollable variables. These weights are used in the Plan performance analyses done by the Association in its performance improvement activities with Plans. For example, regression analysis of our statistical base supports the Travelers' ranking of outpatient claims and we have incorporated a weighting factor for it in our comparative performance indicators for the Plans. We were not able to discover and adopt a factor for the other claims. In the case of the inpatient skilled nursing facility bills, current indications are that the percentage of these bills in each subcontracting Plan, of the total of the total of all bills processed, is too low to produce a significant and therefore a usable weighting factor.

Third, the essential nature of the report is that of a comparative statistical analysis of the operations reviewed. As such, the report appears not to have and may in fact not have taken into account the effect on such a statistical analysis, of variations of a significant nature in the quality of the opertions reviewed. For example, the workload (claims) statistics shown on pages 17 and 18 may be, to a significant degree, affected by variations in the commitment to careful attention and follow-up on questions of medical necessity of services provided and appropriateness of the level of care provided to the type of institution in which it was provided. To state it another way, should the care have been provided in a hospital, or in a skilled nursing facility? An unreasonably low commitment to such quality aspects will result in very low pending workload statistics. Conversely, an unreasonably high commitment will generally evidence itself by very high pending workload statistics. Another facet of the same quality-impact question can be found in an organization that staffs for very high-quality operations so that the impact is not found in the pending workload statistics, but rather in a noticeably high per-claim administrative cost as well as a lower productivity per unit of net productive hours. Similar effects of variations in quality of operations are also found in other aspects of an Intermediary operation, such as auditing of providers where professional judgments are vital to determinations of the scope of such audits as well as determination of complex provider cost questions. Our experience in analyzing potential performance problems, identified by statistical comparisons, has in some instances revealed variations of quality as being significant in contributing to the statistical variation. The need is, of course, to assure there is neither an inadequate nor an excessive commitment of resources to the quality aspects of the Intermediary functions. Program guidelines are helpful in making these determinations, as well as the experience and judgments of all Intermediaries where Program guidelines are not definitive.

Finally, on age 28 of the draft report, there is a recommendation that the Committee consider amending the Act to permit redesignation of an Intermediary when the provider's selection does not appear to be consistent with efficient administration because of the small number of providers served by the selected Intermediary. As we read Sections 1816(b) and (e) of the Act, the Secretary already has the necessary authority to take actions as suggested in the draft report when questions of efficient administration are raised due to small numbers of providers being served by one Intermediary, in specific areas of the country or generally.

If you or any members of your staff want to discuss any of these comments, please let me know.

Very truly yours,

Bernard R. Tresnowski.

Note: Page numbers cited may not agree with the actual location of the material.

APPENDIX VI

Medicare

July 23, 1975.

Mr. Gregory J. Ahart,
Director, U.S. General Accounting Office, Washington, D.C.

Dear Mr. Ahart: The Performance of the Social Security Administration In Dealing Directly with Institutional Providers of Medicare Services Compared with the Performance of Private Fiscal Intermediaries. We are pleased that the captioned Draft Report recognizes that there are significant differences in the cost for administering the Program for various types of providers (Hospitals, Skilled Nursing Facilities, and Home Health Agencies). For example, in handling a comparable number of claims, The Travelers must administer the program for 689 providers as compared to 94 for Maryland Blue Cross. We find that the facts as they pertain to The Travelers are essentially correct for the period reviewed. We sincerely appreciate the opportunity to review and comment on this report.

Very truly yours,

L. E. Carter,
Second Vice President Medicare Administration.

APPENDIX VII

Mutual of Omaha,
Omaha, Nebr., July 28, 1975.

Mr. Gregory J. Ahart,
Director, U.S. General Accounting Office, Washington, D.C.

Dear Mr. Ahart: We appreciate the opportunity to review the draft of this report. A factor of major significance in Part A performance comparisons is the relative difficulty of claim processing when the preponderance of claims are from skilled nursing facilities and home health agencies as opposed to hospitals. We are pleased to note the question was conclusively researched in this study. This position is further supported by our fiscal 1975 unit cost of $8.24 reduced from the $10.44 reported in this draft. The increase from 27 to 73 in the number of hospitals Mutual serves contributed largely to this reduction.

Sincerely,

B. H. Patterson,
Vice President, Medicare Administration.

APPENDIX VIII

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., August 22, 1975.

Mr. GREGORY J. AHART,
Director, Manpower and Welfare Division,
U.S. General Accounting Office,
Washington, D.C.

DEAR MR. AHART: The Secretary asked that I respond to your request for our comments on your draft report to the Congress entitled, "The Performance of the Social Security Administration in Dealing Directly with Institutional Providers of Medicare Services Compared with the Performance of Private Fiscal Intermediaries." They are enclosed.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

CHARLES MILLER,
Acting Assistant Secretary, Comptroller.

Enclosure.

Overview

The data in the draft report—on which GAO's analyses as well as conclusions are based—is nearly two years old. It reflects neither the improvements that have been made in our direct reimbursement operations, nor the very substantial changes in workload that have occurred since 1973. In this connection, the number of paper bills handled by the Division of Direct Reimbursement (DDR) has risen from 288,000—as shown in GAO's report for calendar year 1973—to 354,000 in fiscal year 1974 and to 654,000 in fiscal year 1975. And actuarial predictions are that the increase will continue for 1976 and 1977. At the same time, there has been only a moderate increase in DDR staff, so that we anticipate a dramatic reduction in DDR unit costs.

Because of our concern that readers of the GAO report would draw opinions and conclusions based on out-dated information, we asked GAO in July for additional time to respond to the report to enable us to include in the response cost data applicable to fiscal year 1975, which will be available by the end of August. [See GAO notes 1 and 2, p. 36 [280]]

We might add that some time ago DDR attempted to develop unit costs for purposes of comparison with the other intermediaries, and these attempts proved unsuccessful, partly for reasons of methodology.

Methodology

The GAO study results are more dependent on methodology than on the actual operations of DDR. For example, bills handled by a tape-to-tape operation established by DDR are excluded from the number divided into DDR costs in determining unit cost on the grounds the bills "are not processed by DDR," even though the costs analyzed include costs such as claims examination, cost auditing, and professional relations with respect to the services represented by these bills. At the same time, automated bills processed by intermediaries are included in developing intermediary unit costs for comparative purposes.

Also, while the report recognizes that billing mix (i.e., occurrence of bills of differing degrees of processing difficulty) is a critical factor in comparing DDR efficiency to that of intermediaries, no effort is made to properly weight billing mix. Rather, the weighting formula developed for internal purposes by an intermediary quite unlike DDR in billing mix and operation is accepted and used in the analysis, even though it is not known whether the weighting factors accurately reflect the relative difficulty of processing different types of bills.

There are other matters that range from major problems, such as charging costs incurred by SSA regional offices in assisting DDR without developing and charging costs incurred by these offices in assisting the intermediaries, to inconsistencies of relatively minor impact on the findings. Of particular note is failure to go beyond budget estimates in allocating costs between the direct dealing provider operations of DDR and the many other functions it performs for the Bureau. A similar approach is taken with respect to costs of activities of other components of Government allocated to DDR operations by GAO.

Perhaps the most serious problem is failure to address in a meaningful way the qualitative factors in intermediary operation. In considering the professional relations aspect of intermediary operation, for example, the report relies on number of reported visits as a measure of performance without any reference to visit content or results. In considering audit effort, the report relies on the number of "audits"—a term that embraces activities that range from limited audits of single aspects of provider operations to full-field audits of the total operations of providers and related organizations—and does not assess the quality of cost settlements based on these audits. The study addresses only the mechanical handling of bills and no aspect of quality in claims processing or any other aspect of the intermediary or DDR operation. The result does not, in our opinion, constitute a valid review of performance.

We are in process of developing updated cost data for submission to the Committee. In this connection, though, we must reiterate that we do not believe that such data can be meaningfully compared with data on intermediary costs on the basis advanced by GAO.

[See GAO note 1.]

We will continue our efforts to develop a methodology capable of weighting bill mix and the many other factors that complicate comparative evaluation of intermediary performance.

GAO NOTES.—1. The data referred to above has been provided to GAO and is included as appendix IX. Therefore, HEW no longer plans to submit it to the committee.

2. The deleted portion is no longer applicable.

APPENDIX IX

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., September 16, 1975.

MR. GREGORY J. AHART,
Director, Manpower and Welfare Division,
U.S. General Accounting Office,
Washington, D.C.

DEAR MR. AHART: In regard to your draft report on the intermediary function carried out by the Social Security Administration, we are enclosing material reflecting fiscal year 1975 costs and workload of the Division of Direct Reimbursement, Bureau of Health Insurance, together with a cost comparison of the Division with the private intermediaries discussed in the report.

We appreciate your consideration of this material in finalizing the report and regret any inconvenience we may have caused you and your staff.

Sincerely yours,

F. D. DEGEORGE,
Associate Commissioner for Management and Administration.

Enclosure.

Attached is the computation of DDR's "intermediary" operating costs for the fiscal year ending June 30, 1975. These costs were delineated and compiled using the same basic approach employed by GAO during their audit of DDR's calendar year 1973 costs.

As you will note from the spread sheet, we processed a total of 1,097,362 "intermediary" bills during FY 1975. This bill count total includes 443,286 magnetic tape bills.

We have segmented the aggregate and unit bill costs as follows:

1. Total intermediary costs attributed to DDR's operation (claims processing, audit, and regional office costs).

$6,242,472÷1,097,362=$5.69 cost per claim

2. Total intermediary costs shown in item 1 less all costs attributed to provider reimbursement and audit ($1,737,425).

$6,242,472−$1,737,425=$4,505,047
$4,505,047÷ 1,097,362=$4.11 per claim

Calculation of DDR's intermediary administrative costs—Fiscal year June 30, 1975[1]

Total DDR salaries, benefits, and other costs	$4, 855, 000
Add:	
Printing (BHI)	76, 000
Division of Management (BHI)	186, 000
Staff Development Associate	25, 000
Subtotal	287, 000
Total	5, 142, 000
SSA Overhead (15%)	771, 300
Bureau of Data Processing	481, 300
Postal	56, 600
Treasury Department	3, 575
Audit contracts	462, 000
GPPP costs of administering Community Health Centers	118, 000
Regional office salaries, benefits, and other	710, 367
Subtotal	2, 603, 142
Total	7, 745, 142
Less:	
Current operation (including RO $20,893)	763, 936
Renal branch	452, 597
Nonintermediary costs	286, 137
Subtotal	(1, 502, 670)
Grand total	6, 242, 472

Claims Processing Costs Including Provider Audit and Provider Reimbursement:

$6,242,472÷1,097,362 claims=cost per claim $5.69.

Claims processing costs including provider audit and provider reimbursement	6, 242, 472
Less: Provider audit and provider reimbursement	(1, 737, 425)
Total administrative costs excluding provider audit and provider reimbursement	4, 505, 047

$4,505,047÷1,097,362 claims=Cost Per Claim $4.11.

Claims processing costs (per above)	4, 505, 047
Less remaining regional costs included in above	(548, 445)
Total administrative costs excluding audit and regional offices	3, 956, 602

$3,956,602÷1,097,362 claims=Cost Per Claim $3.61.

[1] Above calculations include 443,286 tape-to-tape billings.

ADMINISTRATIVE COSTS—JULY-JUNE, FISCAL YEAR 1975

Intermediary	Bills processed	Unit cost per bill (excluding audit)	Unit cost per bill (including audit)
DDR	[1] 1,097,362	[1] 4.11	[1] 5.69
Travelers	490,063	6.98	9.41
Mutual	390,406	5.87	7.80
Chicago BC [2]	1,217,441	3.72	4.62
Maryland BC [2]	386,061	3.72	4.57
Total BC plans [2]	23,156,663	4.64	5.76
Total commercials	2,566,691	5.46	7.17
Total BC plans and commercials	25,723,354	4.72	5.90

[1] Includes tape billings.

[2] Includes BCA costs of $0.29 for model system users, and $0.23 for nonmodel system users. (Maryland BC uses model system; Chicago does not.)

Mr. DUNCAN. I think it shows the average cost of auditing was $12.39 compared with $7.31 for Travelers, and so forth.

Has private industry considered playing an active role if HMO's are utilized as part of a national health insurance program?

Mr. RATHGEBER. Yes. In fact, this bill does encourage the formation of HMO's. Some private insurers have been active in forming HMO's already. It is a form of delivery which we think is a good one, which can be economical, and a number of companies are experimenting along these lines to see what role they can fill to promote the HMO form of delivery.

Mr. DUNCAN. Thank you very much.

Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Burleson?

Mr. BURLESON. Thank you, Mr. Chairman. I apologize for not having been here to hear your initial statement, but I have read it, and of course I am in agreement with your views. Mr. Pettengill and Mr. Hemry are oldtimers before this committee, and I know the chairman and others welcome them and Mr. Rathgeber.

We are very happy to have you.

Yes, Mr. Chairman, strangely enough, I subscribe to the views these witnesses express, and I take advantage to say that I think this is the approach to any national health legislation if we want to stay out of socialistic medicine and socialistic health care.

Mr. Meany was here yesterday, and he answered a question in the discussion relating—quite a lengthy discussion on the subject of cost of Government administration versus the private sector of health insurance.

What, generally, are problems you see with the so-called health security program which Mr. Meany discussed yesterday, in broad outlines, or specifics?

Mr. RATHGEBER. Well, we see many problems. I might just mention a few.

First of all, the method of financing is one which would greatly increase the tax burden of the country, both from general revenues and from social security taxes.

As I pointed out in the testimony, we feel that the country is already overburdened with taxes, and a terrific new load, maybe $60 or $70 billion of additional national taxes, would be a very undesirable thing.

Another major objection is the way the program would be administered. It would have the Federal Government be the administrator, and as we point out, we just do not think that a vast bureaucracy would be as efficient in administering a program as having the competition of private insurers that have been doing this kind of work for many years.

The third objection, I think that the act professes to provide complete benefits for everybody, but the cost control is that we will limit the number of dollars spent in any one year. When you run out of dollars, you do not have any more benefits, and I think this is a rather poor way to provide benefits. You suddenly tell people that there is no more money.

These are just a few. There are many others, and we would like to submit a supplementary statement, if we may, to list the many objections, but those are some major ones that occur to us.

Mr. Burleson. I ask unanimous consent that that be submitted.

Mr. Rostenkowski. Without objection, so ordered.

[Information referred to follows:]

The Deficiencies of the Kennedy/Corman Bill, H.R. 22/S. 3

The Kennedy/Corman national health insurance proposal would create a single, federal program to take over the financing of practically all health care in the United States. In our opinion, such a monolithic approach is unreasonable, unrealistic, and unworkable. A number of the inherent deficiencies we find in the bill are highlighted below.

H.R. 22/S. 3 would add an enormous tax burden

To finance half of its costs, this proposal calls for a tax on employer payrolls of 3½ percent and a tax of 1 percent on employees' wages up to $24,750 in 1976, i.e., 150% of the Social Security tax base. Unearned income and pensions would be included in the wage base. The other half of the costs would be supported by general revenues. This latter, of course, means significant increases in personal and corporate income taxes. The public is not demanding from its governmental officials further increases in its taxes, further federal deficits, and pre-emption of the private sector. To the contrary, the American public has long since reached the limit of accepting further major increases in the tax burdens that they are willing to bear.

H.R. 22/S. 3 would distort national priorities

Good health does not depend solely or even primarily on health care. Decent housing, adequate diet, and a clean environment are all necessary conditions for good health. The Kennedy/Corman bill, however, would increase government payments for medical care by some $78 billion at the time when many other national problems which affect health—such as urban blight, air and water pollution, unemployment, and poverty—require government action and large appropriations of public funds if they are to be resolved. In fiscal year 1974, the federal share of national health expenditures was $28.3 billion, roughly 11 percent of total federal outlays. Federal expenditures for health would rise to about $115 billion in fiscal year 1977 if the monolithic proposal were enacted. This would push the federal budget to more than $475 billion, with almost one-fourth of the total earmarked for health programs.

H.R. 22/S. 3 would be a waste of tax revenues

There is a limit to the federal government's capacity for raising revenues through taxation. To pre-empt so much of that capacity for medical care would mean that other social priorities would suffer.

The fiscal responsibility of the Kennedy/Corman proposal is further demonstrated in that the billions of tax dollars it would cost would be used to pay for the health care of the affluent as well as the poor. Economist Mark V. Pauly of Northwestern University points out that the program would finance additional use of medical care for the poor and near poor, who frequently lack medical care, and in this respect the program would be desirable. However, much of the cost of the program would simply represent additional and excess use of medical care by the non-poor and the affluent. Such a wasteful result leads him to conclude that "the efficient approach is to direct public funds to those people who are thought to be most in need, and to avoid as far as is possible the commitment of such funds to proposes that people can accomplish as well or better privately."

H.R. 22/S. 3 would increase employer operating costs

Although passage of H.R./S. 3 would effectively eliminate employee health benefits as a subject for collective bargaining, it would increase rather than reduce an employer's labor costs. His contributions to health benefit programs would be shifted from insurance premiums to tax payments at a higher level.

Moreover, when health care becomes "free" and is no longer a benefit provided as a condition of employment, collective bargaining efforts will be turned towards increasing benefits in other areas. Union negotiators have already begun to include clauses in their contracts that provide for a reopening of bargaining when national health insurance goes into effect.

The bill itself provides that enactment would not relieve an employer of any existing contractual obligation to pay for health services to employees, retirees or their dependents. It would be the sense of Congress that, if the employer's aggregate obligations for health services (including payroll taxes) were reduced, he should apply the savings to payment employees' health security taxes or to other benefits, at least for the period of any contract in effect at enactment.

H.R. 22/S. 3 would eliminate consumer responsibility

A consumer's sense of responsibility for prudent use of health resources would be eliminated by the passage of this bill. Under this proposal there would be no deductibles and coinsurance payments. Such an approach flies in the face of advice of experts in this field in this country. It differs from most health care programs in other countries which are supported by public funds. All incorporate some form of cost sharing.

H.R. 22/S. 3 would encourage increased utilization

This proposal would result in increased utilization since medical care would be "free" to the consumer at the point of consumption. The use of price as a mechanism to keep supply and demand in balance would be removed. Inasmuch as resources are limited and the demand is virtually unlimited, existing resources would be severely strained by the uncurbed demand.

H.R. 22/S. 3 would create severe economic dislocation

Under this proposal, private health care insurance would be scrapped and replaced by a federal government bureaucracy. This would not only disrupt millions of existing contractual arrangements but would create severe economic dislocation for the 500,000 employees of the health insurance industry. It would have a financial impact on state governments as well. During 1974, states received about $370 million in premium tax income from private health insurers.

The federal government would have to establish, in effect, an enormous insurance company with every citizen as a client. The cost of such an undertaking has not even been calculated. The training and organization involved would take years. Such knowledgeable people as Senator Ribicoff of Connecticut and former HEW Secretary Casper Weinberger have testified before your Committee to the fact that the federal government is not capable of handling such a massive program.

The transfer of the health insurance function would have enormous economic and social costs. Yet, many supporters of H.R. 22/S. 3 appear to be intent upon the destruction of the private health insurance industry. Medical economists Herman and Anne Somers noted this fact in a paper given several years ago before the Sun Valley Forum on National Health. They also noted, however, the fallacious basis of this attack on the insurance industry. They said:

In some quarters, disenchantment with the shortcomings of private insurance has apparently led to the conclusion that we must now make a complete reversal and turn the entire problem over to government. Increasingly, such advocates blame all the ills in the financing and organization of health services upon the omissions and commissions of private health insurance. This not only vastly exaggerates the powers that the industry has, or should have, but also ignores the social climate. What is now generally demanded in this field was neither acceptable nor even possible only a few years ago. The social milieu of 1971 cannot sensibly be set as a standard to evaluate behavior in an earlier and different context.

These critics tend to forget that the same errors and omissions they attribute to private health insurance were also made by government. The failure to develop effective controls over costs or to restructure the delivery system is just as true of government programs—Medicare, Medicaid—as it is of private health insurance, and for the same social reasons.

H.R. 22/S. 3 could have major adverse effects on the health care delivery system

The monolithic approach envisioned by this bill is so impractical, inflexible and impersonal that its enactment would have a disastrous effect on the health care delivery system.

It is impractical and unrealistic to suggest that the Social Security system offers a model for a single government health insurance agency. The Social Security Administration collects and distributes money on a formula basis, with no discretionary freedom. A single governmental health system, however, would be involved in a vast number of judgmental issues. Health care is the most personal of personal services. The health needs of each individual differ. Care provided can range in complexity from a simple bandage to open heart surgery. Treatment may be appropriately provided by a visiting nurse or, depending on the case, may require the full array of services of a major medical center.

Furthermore, the proposal that a central agency should set the budgets for health care for every region, and for every health care institution, is beyond the planning and budgeting capability which exists within the federal government. And even if such capability existed, the serious question would arise as to what would happen to the health care needs of a given area if its allowable budget is exceeded. The job of organizing and financing health care in a country as large and as diverse as the United States is one which requires the efforts of both the public and private sectors.

A monolithic system is inflexible in that it lacks the challenge of competing, alternative systems. It tends to become routinized and rigid. The web of regulations necessary for the continued operation of a vast bureaucracy tends to encourage conformity rather than diversity. Innovation is stifled.

At the present time in this country, medical care organization is a dynamic, rapidly changing field in which there is considerable experimentation. Too little is known about the "best" way to organize medical care to warrant freezing any particular pattern in the mold of a monolithic system. Economist Victor Fuchs has suggested that there is no single best health care system. He said:

"People have different needs, and there isn't likely to be one system that serves them all. Even if there were one system best for everyone, I doubt that we have wisdom to know what it is. I also would say this, even if there were one system that was best, and even if we were smart enough to know what it is, it is not likely that would still be the best system five, ten or twenty years from now."

Mr. Fuchs's words have particular significance when one considers that the organizational reform now proposed by everyone, namely the expansion of prepaid group practice, is based largely upon the success of the Kaiser Foundation Health Plan. Yet, the Kaiser Plan began in the private sector and grew despite the impediments of governmentally created legal restrictions. If a monolithic program had been adopted in the forties, it is doubtful whether the Kaiser approach could have emerged.

The monolithic system is impersonal. This is particularly so where a proposal, such as H.R. 22/S. 3 would give preferential treatment to a single type of health care organization, prepaid group practice. This is not likely to preserve a diverse health delivery system offering freedom of consumer choice. The extent of governmental control of health care organization and delivery stipulated would inhibit the development of competing health delivery organizations responsive to consumer desires. A curtailment of consumer choice, which stimulates innovation, is one of the most serious weaknesses of a monolithic system. Without a pluralistic system, the only option becomes what government services provide—be they good or bad.

The track records of government agencies responsible for programs of direct patient care do not inspire confidence. Too often they are characterized by impersonal, mediocre care, and inadequate financing. Two examples will suffice—the municipal hospital systems of many of our major cities and at the federal level the Indian Health Service.

When the budgeting process for health services is carried on within a political framework, decisions are not always made and funds are not always allocated purely on the basis of medical and health considerations. When other needs are pressing, health budgets tend to be cut.

The unwieldiness, inflexibility, and unresponsiveness of a single agency responsible for administering the total health care of the entire country are depressing to contemplate.

H.R. 22/S. 3 will not result in reduced medical costs

Total health care costs are the product of two factors. First is the cost per unit of service. Even though reimbursement may be based on a broader unit, such as payment per case or per capita, the cost of each service provided must be met. The second factor is utilization—the number of services used. Together, the unit cost and utilization account for the total cost of health services for a given population.

The Kennedy/Corman bill, as noted earlier, would positively encourage greater utilization of services. While it would apply some of the methods which are now available in the mixed public-private health care systems to control unit costs, it places relatively little emphasis on this objective.

Rather, it would attempt to control total costs by placing a limit on the amount of funds available for health care. This approach fails to take into consideration the fact that the incidence of a service is not wholly within the control of either the patient or the physician and that the number of such services that the nation may properly need in any one year can vary significantly from year to year. The variation by locality is even greater. Thus, it would be an impossible task for the federal government to establish a tight limit on health care expenses and to allocate the funds on any reasonable basis by area.

It is true that the utilization of services can be controlled by limiting the resources for providing the services. Since the demand for health care is virtually without limit, any undue limit on resources is bound to put pressure on prices. If prices are then held, either the quality of the service will be cut or the quantity will be cut, with the result that people will not be able to get the care they seek.

H.R. 22/S. 3 places undue reliance on a single form of medical care organization

Through provisions for financial assistance and a system of reimbursement which favors the prepaid group practice method of organizing medical care, the health security program would promote this type of organization, to the almost complete exclusion of any other.

The wisdom of this course is open to doubt. One has to ask why doctors or groups of doctors would not tend to give second rate assemblyline medicine if they are being paid only on the basis of the number of patients they handle. It seems reasonable to hope that HMO's can deliver good care in a more efficient manner than conventional medical organizations but the basic reasonableness is really all we have to go on to date. There is some evidence that existing HMO's, like Kaiser-Permanente in the West and Group Health in Washington, deliver good care at a comparatively reasonable price and the hospitalization rates are lower than average. But the populations served by these plans are self-selected and are, in some ways, untypical. It has not yet been finally determined that the results of these plans can be replicated on a wider scale or how patients and doctors will react to the spread of group prepaid medicine.

The high priority placed on the development of prepaid group practice and the preferential treatment proposed for such organizations are somewhat dubious in view of the fact that during the past 30 years this form of medical care has met with something less than overwhelming acceptance by the public and the physicians, upon whose cooperation the effectiveness of any health care delivery system ultimately depends. In addition, many years of effort are required between the organization of such plans and the date when they can become fully operational. During such tooling up periods, the consumer could find it difficult to obtain the care he required. It may well be that no single organization form is most appropriate. In any case, the decisions and choices should be left to the consumer, given the widest possible choice, and should not be made for consumers by government.

H.R. 22/S. 3 would lead to federalization of the health care system

Despite protestations to the contrary by supporters of H.R. 22/S. 3, the bill will lead to an eventual federalization of the health care system. Under the proposal, the Federal government would be the sole purchaser of health care services and supplies. As the government strives to assure itself, through tighter and tighter regulations, that its money is being spent properly, doctors, hospitals, drug stores, and other providers would become in effect, nothing more than employees of a giant monopolistic employer.

Mr. BURLESON. In testimony on Government run insurance health programs, it was asked that if we could not run the Post Office Department, how could we run a national health insurance plan. It seems to me to have some validity in comparison.

Thank you.

Mr. ROSTENKOWSKI. Mr. Cotter will inquire.

Mr. COTTER. Thank you very much, Mr. Chairman.

Mr. Meany, when he was before the committee yesterday, stated that we are already spending some $118 billion a year for health care, and that actually the Kennedy-Corman bill, if it were enacted into law would cost this country no more than we are already paying.

Can you comment on that?

Mr. RATHGEBER. Yes, sir.

Mr. COTTER. I presume you have had a chance to examine the Kennedy-Corman bill?

Mr. RATHGEBER. Yes, I have, and I just do not believe those two facts can hold together.

Mr. COTTER. I do not either. That is why I am asking your opinion.

Mr. RATHGEBER. If we give additional benefits to everybody in the country it must raise the total costs. Plus the fact, as I mentioned earlier, we feel the administrative costs would also increase, which would be in addition to the increased benefit costs.

Mr. COTTER. Let's get to that, now. He also alluded to the fact that this is a great deal of money wasted in acquisition costs, advertising and other things in the private sector. Would you give me a breakdown on the health premium, both individual and group?

Mr. RATHGEBER. I will ask Mr. Pettengill to fill in on that.

Mr. COTTER. He is an old friend from my hometown.

Mr. PETTENGILL. Today, approximately 80 percent of the private health insurance is written on a group basis, and here, the expense rate admittedly does vary with the size of the policyholder. Also the division of work which is made between the policyholder and the insurance carrier causes variations. However, for the business as a whole, group insurance averages about 8 percent in administrative expenses. In addition to that, you have your premium taxes.

For individual insurance, you do have a major problem in that the people do not walk in and say, "Please, may I have insurance?" You have to send somebody out to sell it to them, so that individual insurance has additional administrative costs, and much higher acquisition costs. They run in the neighborhood of 40 percent.

The point to remember, however, is that under a national health insurance program, you would have a far greater use of the group mechanism than today, so that most people would be covered under a group-type arrangement. In addition to that those few remaining individual policies which you would have for the people who are self-employed, we would have undoubtedly a better—a lower—expense rate, because these people would be buying better quality coverage, which has a higher average benefit.

The same expense dollar divided by a higher average benefit would give you a lower expense rate. So in reality, you are going to, in my judgment, see a much lower figure even for the individual insurance costs, and the amount of the acquisition expense that the labor people have complained about will be negligible.

Mr. COTTER. Is it not true that your nonprofits like Blue Shield and Blue Cross are down to about 6 or 7 percent, and even at that rate they are paying a 2- to 3-percent premium tax, so that the private insurers can also approach that area in the national health insurance program?

Mr. PETTENGILL. That expense figure would be without premium taxes. In most States they do not pay premium taxes. In a few they do.

Mr. COTTER. I know they do in Connecticut.

I was wondering, with the unanimous consent of the board, if you gentleman could look into the cost of this approach, the Kennedy-Corman approach, and give us some indication of what you think that coverage would cost and what the additional cost to either the taxpayer or the consumer would be.

Mr. ROSTENKOWSKI. Without objection.

Mr. RATHGEBER. We can do that.

[Information referred to follows:]

Our actuaries estimate that the total first year cost of the Kennedy/Corman proposal will be $107.8 billion in fiscal year 1977. In that year, an estimated $30.1 billion would be spent by such existing government programs as Medicare and Medicaid. Inasmuch as the Kennedy/Corman proposal would replace such programs, the net additional funding required for H.R. 22/S. 3 would be $77.7 billion.

Mr. COTTER. Thank you very much.

Mr. ROSTENKOWSKI. Mr. Rathgeber, what do you estimate the bill you support would cost the Government?

Mr. RATHGEBER. We have made some estimates, and we think that the total additional costs to the Government would be about $10 billion—$10 billion, or slightly over that.

This is a high figure for two reasons, first because there is a substantial increase in benefits, primarily for the poor and the near poor. You have greatly increased their benefits with very low costs to them.

The second reason is that there are tax incentives in therefor encouraging compliance with the standard minimum benefits. These will, of course, cost the Government some money.

Mr. ROSTENKOWSKI. Your estimates include taxes and expenditures?

Mr. RATHGEBER. Yes, it does, but the net to the people of the country comes out to about $10.3 billion.

Mr. BURLESON. Would you yield, Mr. Chairman?

Mr. ROSTENKOWSKI. Yes; I yield.

Mr. BURLESON. This is after the program would be fully phased in?

Mr. RATHGEBER. Yes.

Mr. BURLESON. And the net increase over present costs would be what?

Mr. RATHGEBER. The net total extra cost to the citizens of the country would be about $10.3 billion.

Mr. BURLESON. That is after a 4-year period?

Mr. RATHGEBER. This is essentially the first major phase of the program, which covers most of the benefits. I would be happy to provide a complete breakdown of the costs for the record.

[The information follows:]

ESTIMATED COST OF THE NATIONAL HEALTHCARE ACT OF 1975 (S. 1438 AND H.R. 5990) BY THE HEALTH INSURANCE ASSOCIATION OF AMERICA

I. INTRODUCTION

The Act (S. 1438 by Senator McIntyre and H.R. 5990 by Representative Burleson) provides for programs to increase and redistribute the supply of health manpower, promote the development of ambulatory care, improve cost and quality controls, develop national health objectives, and extend comprehensive health insurance to the entire population. These programs would be accomplished through a private-governmental partnership, with each partner, in varying degrees, sharing in the cost of implementation.

This memorandum contains estimates of the added costs to government to improve the delivery system for fiscal 1976 and 1977 and of the additional tax burden resulting from the expansion of comprehensive health insurance for fiscal year 1977.

II. ADDED COSTS TO FEDERAL GOVERNMENT FOR INCREASED HEALTH MANPOWER, AMBULATORY CARE CENTERS AND RELATED ITEMS

The Act calls for the following increases in Federal Governmental expenditures in fiscal year 1977. Also shown for comparison are expenditures to be appropriated for fiscal year 1976, which is a 15 month year due to the change in fiscal date.

[In millions of dollars]

Item	1976	1977
Title II—Health care personnel training, scholarships, and waiver of loans:		
Health professions	62.5	50
Nurses	50	40
Allied health professionals (grants)	12.5	12
Allied health professionals (loans)	18.75	15
Grants to medical and other schools	12.5	25
Grants for services in deprived areas	12.5	50
Title III—Grants and loan guarantees for developing and building ambulatory care centers	200	200
Title IV—Health policy board	1	1
Total	369.75	393

III. BENEFITS

The Act sets minimum standards of covered charges prior to 1985 as follows:

1. For both physical and psychiatric care, unlimited hospital in- and out-patient services.
2. All professional services for the diagnosis or treatment of injuries, illnesses or conditions other than dental and mental, by or at the direction of a physician.
3. The first 20 out-patient mental health visits.
4. Drugs and contraceptive devices that require a prescription.
5. 180 days of skilled nursing care.
6. 270 days of home health care.
7. Use of radium or radioactive materials, oxygen, anesthetics, prostheses and rental of medical equipment.
8. Oral surgery on impacted teeth, and for a tooth root.
9. Diagnostic X-rays and laboratory tests performed other than while an in-patient in a hospital or skilled nursing facility.
10. Well child care, including immunizations for children under age five.
11. One oral examination per year, including prophylaxis, dental X-rays, topical application of fluoride and insertion of space maintainers, by a dentist or, at his direction, a dental hygienist, for children under age thirteen.
12. One eye refraction per year for children under age thirteen.

13. Counselling on family planning and fitting of contraceptive device.
14. One PAP smear every two years for women age nineteen and over.

There will be a maximum deductible of $100 scaled down to $10 based on family income, and a copayment of 20% (50% for out-patient mental in No. 3, page 2) except that the total of deductibles and copayments for a family in a year shall not exceed $1,000 scaled down to $100 based on family income. Additional benefits and covered charges are provided for 1985 and later but no cost estimate has been included for these at this time.

IV. ADDITIONAL TAX BURDEN TO FEDERAL, STATE, AND LOCAL GOVERNMENTS TO EXTEND COMPREHENSIVE HEALTH INSURANCE TO POOR AND NEAR-POOR UNINSURABLES

In this section of the report, the additional tax burden is developed by estimating the excess of the total administration and claims costs of the low income population (including the unemployed) less their contributions, over the comparable spending already committed for Title XIX coverage for the low income population.

A. Unit Claim Costs

The estimated annual claim costs per covered person are presented in the table on page 6. These claim costs represent the per capita morbidity costs (benefit payments) anticipated in 1977 for the insured benefits provided by The Act. They are based on the level of morbidity costs that has been observed for a broad exposure of actively employed persons and their dependents covered by group insurance during the early 1970's as utilized for group insurance policy years commencing in 1974 (central experience date 1/1/75). These costs were projected to fiscal year 1977 (central experience date 4/1/77) based on recent trends under health insurance plans covering similar services. These trends, which vary by type of service, reflect not only price inflation of unit costs but also reflect the increase in the utilization of health care services, including the gradual and continuing growth in the number and complexity of services and treatments. Therefore, any tempering in the rate of price inflation, for example, would only affect that portion of the overall trend pattern that reflects the past pattern of price increases. The price inflation projection averages 12% per year while the utilization projection is 3% per year.

The Act calls for a significant number of controls on costs, programs to induce a shift in site of care from institutional to less-costly ambulatory services and increases in manpower and facilities. It is realized that these measures will produce the intended result only after a transition period and, therefore, will not have a major effect upon claim costs during the initial year.

Accordingly, estimates of the claim costs have been based upon current levels of manpower, current cost control procedures, and current emphasis upon institutional care.

The indigent and near indigent population are believed to be in a relatively poorer health status than the population of employed persons and their families. Therefore, the indigent and near indigent might be expected to generate higher claim costs than those presented here. However, the limited evidence available does not show the poor to have higher claim costs initially. Studies comparing initial utilization experience of OEO and Title XIX populations that were enrolled under insured plans to the cumulative utilization experience of regularly insured groups in Portland, Oregon and New York City, show no essential differences in claim costs. More mature experience has not as yet been published. This apparent similarity in the utilization rates need not mean that the poor are as healthy as the non-poor but rather that they may lack a familiarity with the insured benefits available and be reluctant to seek medical care. In addition, it should be noted that the claim costs presented are based on a population which has had considerably greater access to medical care than the poor. In the light of these counterbalancing factors and the data which are available, the claims costs are felt to be appropriate for the poor and near poor in 1977.

The estimated annual claim costs per person are presented on the following page, for the Qualified State Healthcare Plan benefits, according to the deductible and maximum copayment.

Family income			Deductible	Maximum copayment	Unit claim cost		
1 person	2 persons	3 plus persons			Child	Adult under 65	Adult over 65
Under $1,000	Under $1,500	Under $2,000	$10	$100	$215	$521	$322
$1,000 to $1,500	$1,500 to $2,250	$2,000 to $3,000	20	200	204	501	313
$1,500 to $2,000	$2,250 to $3,000	$3,000 to $4,000	30	300	194	483	304
$2,000 to $2,500	$3,000 to $3,700	$4,000 to $5,000	40	400	184	465	295
$2,500 to $3,000	$3,750 to $4,500	$5,000 to $6,000	50	500	174	447	287
$3,000 to $3,500	$4,500 to $5,250	$6,000 to $7,000	60	600	165	431	279
$3,500 to $4,000	$5,250 to $6,000	$7,000 to $8,000	70	700	157	415	271
$4,000 to $4,500	$6,000 to $6,750	$8,000 to $9,000	80	800	149	399	263
$4,500 to $5,000	$6,750 to $7,500	$9,000 to $10,000	90	900	141	384	255
$5,000 and over	$7,503 and over	$10,000 and over	100	1,000	134	370	248

B. Eligible Population

The Act provides that certain families with low earnings, would be eligible for insurance under a Qualified State Healthcare Plan. These are Federal cash recipient families and families with income under $5000 single, $7500 two persons or $10,000 three or more persons who are not insured under an employer plan. Data were obtained from publications of the Bureau of the Census with respect to a distribution of the population by size of family by income and by employment status for calendar year 1973. These data were projected to fiscal year 1977 and it was estimated that about 45 million persons would be in the several income categories eligible for Qualified State Healthcare Plan coverage in fiscal year 1977, as shown by the table on the following page.

PROJECTED ENROLLED POPULATION

[In thousands]

Family size and income	Children	Adults under 65	Adults 65 and over	Total number of persons	Total number of families
Single under $5,000	0	3,321	4,853	8,174	8,174
2 persons under $7,500	810	5,161	5,293	11,264	5,632
3 plus persons under $10,000	12,271	10,537	2,995	25,803	6,157
Total	13,081	20,019	13,141	45,241	19,963

Benefits for Qualified State Healthcare Plan beneficiaries would be the same as for everyone else except for the lower deductible and maximum copayments, as shown in the table on page 6. Application of the unit claim costs for these benefits to the eligible population produces the estimated first year claim costs for the poor and near poor under Qualified State Healthcare Plans of $14.7 billion, as shown in the following table:

ESTIMATED CLAIM COST FOR QUALIFIED STATE HEALTHCARE PLANS

[In millions of dollars]

Family size and income	Children	Adults under 65	Adults 65 and over	Total
Single under $5,000	0	1,554	1,417	2,971
2 persons under $7,500	152	2,333	1,528	4,013
3 plus persons under $10,000	2,184	4,687	846	7,717
Total	2,336	8,474	3,791	14,701

The population projection methods were judged, after critical review, to be more likely understated than overstated. As shown in section H on page 10 an additional margin of approximately 10% or $1.4 billion was, therefore, added.

C. Cost Effect of Uninsurables

The Act provides that persons and groups not insurable according to normal underwriting shall nevertheless be accepted and shall be reinsured in a separate pool with reasonable rates. The losses of this pool will be shared by all carriers in proportion to their total business, the gains will be retained by the pool to cover contingencies or reduce rates. There will be no federal or state cost.

D. Cost Effect of Unemployed

The Act provides that persons unemployed for longer than two months who meet certain income qualifications will be eligible for benefits under the Qualified State Healthcare Plan. The estimates in section B include the cost for such persons.

E. Administrative Expenses

The administrative expenses which will be required to provide the benefits for the Qualified State Healthcare Plans will depend upon a number of critical factors. Certainly the question of beneficiary eligibility and identification will be a difficult one, particularly where individuals enter and leave eligibility status as their economic condition changes. As with any new program there will also be necessary start-up costs. For purposes of this cost estimate, the on going administrative costs are estimated at 10% of premiums.

F. Contributions by the Near-Poor and Unemployed

The Act provides for contributions by the near-poor and unemployed under the Qualified State Healthcare Plan, who are not federal cash recipients. The amount of contribution is –0– for families with incomes below the lower limits in the table below, 10% of the excess of their income over these lower limits for near-poor and unemployed families eligible on the basis of prior year's income and at a monthly rate equivalent to 10% of the excess of maximum eligible earnings over the lower limits for other near-poor and unemployed families. In all these cases, the contribution for Healthcare is reduced by the contribution for Medicare Part B. The net total contributions are estimated to be $1.8 billion.

Family size	Earnings for contributions	Number families (thousands)	Contributions (millions)	Average per family
Single	$2,000 to $5,000	3,352	$414	$124
2 persons	$3,000 to $7,500	2,802	566	202
3 plus persons	$4,000 to $10,000	2,976	864	290
Total		9,130	1,844	202

G. Medicaid Expenditures of Poor and Near-Poor

During fiscal years 1973 and 1974, combined Federal and State expenditures for Medicaid (Title XIX) programs for the indigent and near indigent totalled $9.2 billion and $11.2 billion respectively. Based on the most recent trend in these health care expenditures, costs over the next four years of Title XIX programs are projected to reach $17.1 billion by fiscal year 1977.

It is estimated that approximately 20% of Title XIX expenditures under the present program is for domiciliary nursing home care and, therefore, not covered under this program. Further, some states currently provide coverage to Medicaid recipients that is more extensive than the benefits that would be provided by the Qualified State Healthcare Plan initially.

It is estimated that this difference will amount to 20% of Medicaid spending. The remaining 60% however, would be covered by Qualified State Healthcare Plans. Thus, of the $17.1 billion estimated for medicaid costs in fiscal year 1977, $10.2 billion would be covered by the Qualified State Healthcare Plans which would eventually replace Title XIX as far as health care expenses are concerned. This $10.2 billion must be reduced by the amount the Title XIX programs will pay for the Part B Medicare premiums for eligible persons over 65 because this expenditure would continue under The Act. For fiscal 1977, the amount of such Part B Medicare premium payments is estimated at $200 million, leaving a net credit of $10.0 billion.

H. Summary of Added Cost to Government for State Healthcare Plans in Fiscal Year 1977

	Amount (billions)
Total annual claim costs:	
For poor, near poor and unemployed	$14.7
Plus 10 percent for undercount	1.4
Administrative expenses	1.8
Gross annual cost of State healthcare pools	17.9
Offsets to gross costs of healthcare pool	−1.8
Net annual cost of State healthcare pools	16.1
Title XIX expenditures eliminated in 1977	−10.0
Net calculated additional tax burden	6.1

V. EFFECT ON TAX REVENUE RESULTING FROM TAX INCENTIVES IN THE HEALTHCARE PROGRAM

The major effects on tax revenues estimated in this memorandum result from the net of increases in taxes for those employers who do not adopt plans which meet minimum standards and decreases in taxes due to higher expenditures for improved health insurance programs.

A. Estimated Increase in Expenditures for Health Insurance Programs Qualifying as Employer Healthcare Plans

Under the Healthcare Program there are several courses of action available to employers, depending on the level of insurance now in force, if any. While it is not feasible to identify each possibility statistically, it is estimated that the net result of all decisions will be that 15% of all employers will have substandard plans and 85% will have at least minimum plans.

On the basis of current trends in group insurance expenditures, it is projected that by 1977, an average of $481 per insured employee will be expended for health insurance benefits in the absence of any national health insurance plan. With enactment of the National Healthcare Act of 1975, it is projected that an average of $690 per insured employee will be expended for those employees who are insured under a qualified plan, some of whom will have benefits in excess of the minimum standards in 1977. It is estimated that those 15% of employers who have plans that do not meet the minimum standards will be expending approximately $252 per employee and that those 85% of employers whose plans will be qualified, would have spent approximately $521 per employee. These figures are based upon net expenditures recognizing that many families would be covered under more than one plan in view of the large number of working wives.

B. Net Change in Tax Revenues Resulting from Plan Upgrading

The effects on tax revenues of the various tax incentives of the Healthcare Program are complex and interrelated. Many of the multiple effects will depend upon how taxpayers adjust their spending levels in relation to changes in their health care expenditures. For purposes of this cost estimate, the following areas of tax effect have been evaluated:

1. *Tax Loss Due to Employer Upgrading to at Least Minimum Standards.*—Assuming that 85% of employees will be covered by a qualified program of one type or another, and that employers pay approximately 75% of the cost of health programs, the estimated tax loss is $3.315 billion.

2. *Tax Gain as a Result of Some Employers not Adopting Minimum Plans.*—Assuming 15% of the employees are not covered under a minimum plan, and that employers contribute 50% of the cost, tax gain would be approximately $.147 billion.

3. *Tax Loss Due to Increased Employee Contributions Under Qualified Plans.*—As a result of the increased contributions paid by those employees who presently itemize deductions, the tax loss is estimated as $.371 billion. This figure allows for the fact that claimants will have a smaller deduction for actual medical expenses.

4. *Individual Healthcare Plan Tax Effects.*—Based upon two million self-employed persons purchasing Qualified Individual Healthcare Plans, and the additional one million uninsurables who will have state plan coverage, the estimated net loss in tax revenue due to increased deductions for qualified coverage is $.293 billion.

In summary, the above estimates produce a net loss in tax revenue of $3.8 billion due to tax incentives resulting in upgrading of plans.

VI. SUMMARY

This memorandum outlines the basis and results of an analysis of the major change in government revenue in 1977 that would result from the enactment of the Healthcare Bill. These results are as follows:

	Amount (billions)
A. Added costs for improving the health care delivery system	$0.4
B. Net additional tax burden due to establishment of State Pools for the low income population, uninsurables and unemployed	6.1
C. Net loss in tax revenue due to plan upgrading	3.8
Total	10.3

Mr. Burleson. Thank you, Mr. Chairman.

Mr. Rostenkowski. Thank you, Mr. Rathgeber. Thank you very much.

Mr. Rathgeber. Thank you.

Mr. Rostenkowski. Mr. William Ryan.

Welcome to the committee, Mr. Ryan. Would you identify yourself and the gentleman with you.

STATEMENT OF WILLIAM E. RYAN, PRESIDENT-DESIGNATE, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS. ACCOMPANIED BY LAWRENCE C. MORRIS, SENIOR VICE PRESIDENT

Mr. Ryan. Thank you, Mr. Chairman.

I am William E. Ryan, president designate of the National Association of Blue Shield Plans. With me is Lawrence C. Morris, senior vice president. The association consists of 71 locally based, not-for-profit medical care prepayment plans, employing 55,000 people and covering 72 million subscribers in private business and an additional 12 million as carriers for Government programs. Two of every five Americans look to Blue Shield for financial protection against health care expenses.

We are privileged to appear before you today, as we have been in the past. We testified on national health insurance before the Ways and Means Committee on May 31, 1974, and submitted a statement or our updated views to this subcommittee on April 15, 1975. Our attitudes, for the most part, have not changed, and we commend those statements to your attention. We respect the members of this subcommittee for recognizing the evolutionary nature of the debate over national health insurance, and for your efforts to explore every aspect of this subject before taking action.

The passing of time has convinced Blue Shield more and more that universal nationalized health insurance is a solution to a problem which has ceased to exist. The private financing system of the United States is unique in the world. It has responded to the health-care coverage needs of most Americans. It has served the majority of them quite well. More than 90 percent of all citizens under age 65 now have some form of health insurance.

Carriers have innovated and done much to change the environment. Blue Cross and Blue Shield, for instance, were building health maintenance organizations before Congress acted to encourage them. We have spent millions of dollars to develop systems capable of handling larger claims volumes with increased efficiency. We have spent additional millions to contain health-care cost, and to educate the public to care for its own health. We are continuously working to develop better accounting systems, utilization review programs, and other technical advances to strengthen our programs.

Notwithstanding these efforts, there continue to be problems that private carriers have not been able to solve. Some of these will only be resolved through the active participation of government. Some will require the effort of the whole society, because, Mr. Chairman, they trace directly to society itself.

For example, we share with the members of this subcommittee a very real awareness of and concern for the recent trends in health-care costs. These are due in substantial part that there is today more access to health services than at any time in history. We have more physicians, more hospitals and more health resources in general. People live longer, requiring longer, more intensive care. New devices, techniques, and drugs have been introduced, and they cost money. People are better educated and more aware of the availability and capacity of health-care services. Perhaps most importantly, their expectations are higher.

The United States has placed high social priority on expanding the capacity of medical science and distributing its benefits to the people. This objective is inherently inflationary. Other countries which share it, although in some cases with quite different financing and delivery systems, are incurring comparable cost pressures.

Cost is not the only problem inherent in the system. Geographic distribution of physicians needs improvement. It suffers from modern medicine's reliance on facilities, consultation, and practice coverage.

The distribution of physicians by specialty is not ideal. To a considerable degree our educational priorities have been misplaced. The economic premium that health insurance has placed on the surgical specialties has been largely reversed, but some of its effects will linger for years.

The professional liability crisis continues, exacerbating nearly all of the other problems. A young physician may be unable to go into rural practice alone if he must pay several thousand dollars for malpractice coverage before he begins to earn. Defensive utilization is rapidly becoming a norm. Its impact on cost is enormous.

These problems, and others like them, do not lend themselves to simple solutions. Neither will they necessarily respond to legislative action except gradually, over a long period of time. While they must be addressed, they are not problems to be solved primarily through National Health Insurance.

The concept of a single, all-encompassing bill to redirect the health system, identifying its deficiencies and channeling its dollar flow to effect the necessary remedies, has been a magnificent goal. It is an illusion. The health system is too complex. Its evolution is too rapid. The demands upon it are too varied and conflicting.

With some understanding of and great sympathy for the subcommittee's problem, Mr. Chairman, we respectfully suggest that the Congress cannot move effectively on too broad a front. We believe, on the other hand, that major problems do exist that can only be solved with

Congress' help. These will be handled well, in our view, in direct proportion to Congress' willingness to isolate and define those problems, prioritize them and address them on their merits, with regard for their impact upon other elements of the system.

In general, the problems to be solved by National Health Insurance are not those traceable to the health system itself. Rather, they are those caused by the inability or unwillingness of some people to purchase adequate health-care coverage. And, in honesty, there are characteristics of the health insurance system which should be corrected or improved. Government can be highly effective in these areas if it directs its efforts at the specific problems and applies its financing and regulatory authorities selectively.

The nature of these problems can be stated rather simply:

1. The poor and near-poor are unable to purchase coverage for themselves. They will need public assistance.
2. The temporarily unemployed should be offered coverage during their period of unemployment.
3. Long-term medical care services should be provided to the aged, who are for the most part on fixed incomes.
4. Everyone should have access to protection against insolvency due to catastrophic medical expense, even though relatively few are so affected.
5. Those now classed as "uninsurable" should be able to purchase coverage at reasonable rates.
6. Coverage should be as available to all individuals and small groups as it is now to large groups.
7. The quality of coverage should be assured, and effective carrier performance incentives should be implemented.

If Federal involvement is to be successful, Government's response must be appropriate. Too narrow a response must be appropriate. Too narrow a response is wasted. On the other hand, over-reaction that creates unnecessary confusion, unneeded bureaucracy and unwarranted interference with health care may do even more harm. In short, Federal initiatives should be tailored to meet the identified needs.

The Federal Government has two basic alternatives. It can provide direct financing, or it can extend its regulatory authority to bring about the solutions within the private sector. Direct financing will be required to solve the problems of the poor and medically indigent, the aged, and the temporarily unemployed. In varying degrees, these populations cannot cope with medical costs alone.

POOR AND MEDICALLY INDIGENT

In addressing the poor and the medically indigent, the Government has been and should continue to be responsive to the needs of the impoverished. The medicaid program was a major step in the right direction. However, it suffers from uneven administration and benefit patterns.

Blue Shield recommends that the current medicaid program be replaced by a Federal program offering uniform benefits and improved administration. Federal and State revenues as well as premium contributions based on income and family size would finance the program. Qualified carriers should be used to administer the program within acceptable cost parameters.

AGED

Medicare provides those over 65 with a broad scope of benefits. However, the extended care required by the degenerative and other diseases characteristic of the aged may exhaust their benefits, causing severe financial hardship. The most efficient way to handle the problem of catastrophic illness among the aged is to extend certain aspects of the existing program.

The medicare program itself could remain essentially unchanged. Long-term medical care benefits should be expanded and limits should be placed on the costs to be shared by the patient. Once these limits are fulfilled, the patient should be entitled to full long-term medical care benefits.

Long-term care of a nonmedical nature is a significant need of the elderly which Congress might very well address. However, it is not, by definition, a health insurance problem.

TEMPORARILY UNEMPLOYED

Referring to the temporarily unemployed, medicaid is not appropriate. They are not initially indigent, even though extended unemployment could make them so. The eligibility requirements of medicaid preclude their coverage until they have spent their resources. The situation is further complicated by rapid changes in eligibility, which substantially complicate administration of a program.

Industry should and frequently does accept some of the responsibility for these individuals. It would be reasonable to require a former employer to continue health care coverage for his terminated employee for a period of 30 days. However, after that coverage is exhausted, coverage for the unemployed should be a responsibility of society at large.

This could be accomplished by covering the unemployed with a specific program. Eligibility could be determined by existing unemployment compensation agencies. Financing would be through State or State and Federal revenues, administered by carriers.

Mr. Chairman, if the Federal Government uses its financing authority to assist the poor, the elderly and the unemployed, the other problems we have cited can be resolved, without exception, through regulatory processes. Government financing would be completely unnecessary in these areas. It would result in solutions more massive than the problems.

The Federal Government should establish goals, to be implemented through the States' regulatory mechanisms. In the event a State fails to act, the Federal Government should be authorized to enforce these provisions within the State.

UNINSURABLES

There are persons whose health conditions leave them unable to secure unrestricted health care coverage. This population has often been referred to as "uninsurables." In reality there are and should be no insurables, except those who have declined to get health coverage until they are already sick.

It is Blue Shield's practice that no individual once covered, even as a dependent minor, shall be denied continuing coverage because of health status or excessive medical needs. Once in our risk pool, he may stay for life. On the other hand, the individual who had no coverage before he was sick must look for assistance to society as a whole, not to society as represented only by Blue Shield subscribers.

This practice could be expanded. While a few States have acted to do so, there remains a need for an industrywide mandate, which could be achieved by regulation.

INDIVIDUALS AND SMALL GROUPS

The situation is similar with respect to rates for individuals and small groups. Carriers could be required to community rate these classes, with rates limited in relation to the rates of the carriers' large group business. Carriers should have the option to form pools to extend coverage to individuals and small groups, and should not be subject to antitrust prosecution if they elect this approach.

PERFORMANCE AND QUALITY OF COVERAGE

Two other areas which can be effectively addressed through Federal standards and State regulation are assurance of effective carrier performance and of the quality of coverage. For example, carriers should be required to show evidence of effective utilization review and controls in order to safeguard the interests of their subscribers. They should be required to maintain sufficient reserves and provide protection against their insolvency or impairment. Subscriber certificates should state clearly the benefits and the conditions under which the benefits will be provided.

All promotional activities should be reasonable and avoid misleading statements. Accounting practices should comply with recognized accounting principles and afford a reliable financial statement. All exclusions, waiting periods, deductible provisions, and other limitations should be clearly indicated.

We have gone into more detail on carrier regulation in previous statements, Mr. Chairman, and would be glad to expand our recommendations at the subcommittee's convenience.

CATASTROPHICALLY ILL

We are sensitive to the emotional appeal and surface logic of a freestanding program to protect the catastrophically ill. We have identified this as an unresolved problem requiring positive congressional action. As with other problems, however, that actions needs to be carefully tailored to the real need.

The dimensions of the problem can be deceptive. A study conducted in 1974 by Michael Meyer for the Heritage Foundation indicated that 0.8 percent of Americans incur hospital and medical expenses totaling more than $5,000 per year. Approximately 80 percent of them are either psychiatric or medicare patients.

If we assume that the limitations on psychiatric care in currently proposed legislation for the catastrophically ill would somewhat limit its usefulness to these patients, and that an extension of medicare benefits would alleviate the economic catastrophe problem for that group, it might be reasonable to predict that two or three people per thousand would qualify for a free-standing program at a very considerable cost in administrative expense per beneficiary.

The Heritage Foundation study, however, also indicated that 110 million Americans already have catastrophic coverage in the form of major medical insurance. The additional number eligible for medicaid is unknown, since eligibility is frequently determined retrospectively. In 1973, however, approximately 24 million people actually received medicaid benefits, and total eligibility obviously was higher. Conservatively, it appears that a freestanding catastrophic program would be redundant in some degree in terms of the present coverage of about two-thirds of its potential recipients, and that number is growing constantly.

Nevertheless, many individuals potentially are subject to catastrophic illness. The question, therefore, is not whether catastrophic coverage is desirable, but which is the most efficient way to provide it?

Precisely because of the very low incidence of catastrophic expense, the cost through private coverage of the benefit structure of H.R. 10028, for example, is nominal. We estimate it at from $12 to $18 per year for an individual or from $30 to $45 for a family. This is well within the means of the bulk of the population, the vast majority of whom already have some coverage within that scope. Therefore, we view catastrophic coverage as a regulatory concern, which does not require solution through the Government's taxing and administrative powers.

The most effective approach would be a mandated access program, implemented by requiring all employers to offer both a basic program and catastrophic coverage with a specific level and scope of benefits to all their employees, and to pay at least a percentage of the premium. Identical programs should be offered to the self-employed at a premium not to exceed a maximum percentage of the group rate. A comparably comprehensive program should be available as an extension of the program for the poor and near poor. This, of course, will require expenditure by government through the programs in which we have recommended direct financing.

While it is critical to provide protection for the catastrophically ill, it is just as critical, and a major purpose of this proposal, to do so without disrupting the effectiveness of existing mechanisms.

Financing considerations aside, the major advantage of integrating basic and catastrophic coverage in a mandated program is the ability to integrate their administration, and establish the deductible on a benefit rather than a dollar basis. This continues the administrative practice found most effective for the patient, the provider, and the carrier in 30 years of experimentation in private industry.

The Federal employee program, for example, has spent, on occasion, more than $100,000 per patient from basic coverage, without invading the supplemental or catastrophic benefits. This has occurred because the deductible for the supplemental program is a benefit, not an arbitrary dollar limit. Surgery is deductible. In-hospital medical care is deductible. The incurred costs are and should be irrelevant to the administrative process.

Having basic coverage provide a discrete benefit is far more efficient and economical than interposing an artificial dollar limit. The dollar limit undermines the ability of the carrier to exercise controls, by interrupting its pricing and utilization review process. It forces the expensive re-creation of history and eligibility files. It creates conflicting pricing patterns on the same episode of care. It confuses the patient, the provider and the carrier, and compounds the confusion by making the patient responsible for determining his own eligibility. We have previously cited some of our experience with the dollar deductibles in medicare. Patients have brought shoe boxes of bills to the carriers, pleading for help in understanding the rules of the program.

Perhaps most importantly, the freestanding catastrophic approach may encourage a sense of false security in the patient, leading him to self-insure amounts which may, in themselves, be catastrophic. A freestanding catastrophic program might well result in many patients having less effective coverage than they currently hold, without appreciating the fact. The realization would come when they were least able to cope with the problem, and totally unable to share it actuarially.

The program we have discussed, and elaborated in other filings with the subcommittee, would substantially improve the health insurance status of the United States, which is not, we maintain, a serious problem now for most of its people. It would provide a new plateau from which to examine results and determine which further steps may be needed. It would maintain the ability of existing mechanisms to protect the public and it would not commit the Nation to untried courses from which withdrawal, in event of poor experience, could be overwhelmingly difficult.

We do not suggest that it would resolve all of the problems of health care financing and delivery. But it would help significanctly in those areas in which health insurance is the appropriate vehicle for change. We then would have a much clearer view of the other problems.

A less encumbered view of the potential of other programs would be useful. There are many knowledge gaps to be filled. Environmental hazards can be eliminated or considerably reduced. Manpower development could be accelerated in key areas. Preventive measures could be encouraged. Consumer cost consciousness programs could be stepped up. To wait until a monumental health insurance program can be developed to attack all of these problems simultaneously will not be very productive.

SUMMARY AND CONCLUSIONS

In summary, Mr. Chairman, Blue Shield reconfirms its previous views and recommendations before this subcommittee. Many of the problems most national health insurance proposals are designed to solve no longer exist. The private sector has been instrumental in many of these advances and its continued future role should be assured.

Government can and should work to solve the existing problems. It should provide planning and leadership in the efficient use of resources, establishment of program and regulatory standards, and public funds for health care coverage for those unable to pay.

Blue Shield believes that the problems properly identified with national health insurance can best be solved by following this approach.

Mr. Chairman, we thank you again for the opportunity to present our views. We will be happy to try to answer any questions members of the subcommittee might wish to ask.

Mr. Rostenkowski. Thank you, Mr. Ryan.

Mr. Duncan will inquire.

Mr. Duncan. Thank you, Mr. Chairman. I would also like to welcome you, Mr. Ryan, to the committee, and I have just one question.

Do you believe that home health care benefits should be included as part of a national health insurance program?

Mr. Ryan. For some time now, Mr. Duncan, we felt, along with Blue Cross, that home health care benefits should be developed and should be part of these programs. Obviously the cost of this has to be assessed, but it is a worthwhile direction.

Mr. Duncan. Why do you believe that a system of—or what would be your views on administrative costs of a national health insurance program? Do you think it could be done better by the private insurance industry, or by the Government?

Mr. Ryan. I think we have made our positions rather clear on this over a period of time. We do believe the expertise, the competitive sharpness that exists in the private sector, would lead us to be more competitive in terms of administrative costs than the Government could be. I think if we take a look at the figures where we have an area of comparison, we have found that the private sector has been more than competitive in administrative costs.

Mr. Duncan. During high unemployment did you have a great number of policies that lapsed?

Mr. Ryan. We have attempted to determine this, as a result really, of some of the discussions that we had. There was some lapse in coverage. It was not as severe as I anticipated and projected in front of this subcommittee, as a matter of fact.

There was more than one source of group insurance in certain families, and a large number took advantage of that. I think you probably realize that both Blue Cross and Blue Shield went out and recommended to our plans that they allow immediate transfer from a husband to a wife's account if the husband was unemployed, to attempt to alleviate some of this.

Obviously there was hardship. Obviously people had to take on more expensive and perhaps less comprehensive direct coverage. However, I can't assess at the moment the percentage of people or the number of people who actually did not have coverage during that time.

Mr. Duncan. Thank you.

Thank you, Mr. Chairman.

Mr. Rostenkowski. Mr. Ryan, did you notice an increase in claims during this time of high unemployment?

Mr. Ryan. As a matter of fact, we noticed an increase in claims, which coincided with the increase in unemployment. The cause, and effect, are very difficult to place, but we did see that. Obviously when people are out of work, we saw an increase in surgery.

Mr. Rostenkowski. Mr. Burleson?

Mr. Burleson. Thank you, Mr. Chairman.

Mr. Ryan, as you are well aware, there is strong advocacy for a catastrophic insurance program. You seem to feel it should be adopted now without the remaining health insurance program.

You have given, at least to me, reasons why you do not believe that, but would you oppose any type of catastrophic illness program apart from the national health insurance protection?

Mr. RYAN. Mr. Burleson, if I may, I would like to restate what I said.

First, we believe in the principle of providing catastrophic insurance, in addition to the programs which we have readily available.

We have the concern that the major part of the liability which accrues to an individual, or to us as the carrier, really lies in effective basic coverage. Until you define a good, solid base coverage as the recommended way in which to protect people through their health insurance benefits, the catastrophic becomes a secondary consideration.

We are probably talking of about 5 cents of the health care dollar being in catastrophic as opposed to the 95 in basic where the majority of liability exists.

The other point we attempted to make, and that I personally feel, was that many people who have this kind of insurance have not reasoned that the deductibles and the coinsurance and the base liability could well be a catastrophe to them.

Catastrophe is a relative term. It depends on who you are, and what particular resources you have. There can be a false sense of security. You do not realize the shortcomings of this kind of coverage until you have to use it, which is precisely the time when you can't afford to suffer that kind of disappointment.

Mr. BURLESON. You seem to believe, or at least this is what I get from your statement, that there is a need for further governmental controls of carriers at this time. I am not critical, but I am surprised a little that you feel this is desirable or necessary. I assume it is for more efficiency and less cost. Am I correct that seems to be a thread in your testimony?

Mr. RYAN. You are correct, and it may seem out of character for us as carriers to be saying this. But we do think there is a vast difference between the carriers available to the American population on a free, competitive basis. We do think it is essential that you have good carriers who are sound, who have responsible programs, who are in the business to help people, who accept this responsibility, and who do not spend 40 or 50 cents of each dollar for administrative expenses or reserves.

Over a period of years, I think, this is why Blue Cross and Blue Shield have enjoyed the reputation they have. We are talking about 92, 93, and 94 cents of every dollar taken in being paid out in benefits.

We think the competition with the major health insurance carriers in the commercial field is fine. They have, obviously, a reputation. There is a different philosophy of insurance between the Blues and our major reputable commercial insurance carriers. A number of things could be regulated by the States, and we emphasize by the States, that would bring the total level of carrier responsibility up to reassure the public, which is the real reason for it.

Mr. BURLESON. Just one other comment, Mr. Chairman.

In your statement regarding the desirability perhaps of the employer carrying the insurance premium of the employee who is unemployed, for whatever reason, for 30 days, we now have before this committee an extension of unemployment compensation and a liberalization of it.

My impression is that the business community and the employer generally feel they are burdened by about as many fringe benefits as they can stand for a while, and, you know, if you make it 30 days, it wouldn't be long until it would be 60, and then it would be 6 months. We never get anything smaller around here. It is always expanding.

That is just a comment.

Mr. Ryan. If I might respond so that you will interpret our testimony properly, the 30 days is in reality about the present administrative system that exists in most of the Blue Shield groups. For example, the group will prepay before the first of December for coverage of benefits in December.

If a person leaves the group, coverage is extended through the time that is prepaid which can be as much as 30 days. We appreciate, as you do, the burdens that are put on industry in this way.

In the event that you were to decide on something like 30 days and then inaugurate a program for the unemployed with some Government or State financing, then obviously the expansion would not be necessary beyond the 30 days.

Mr. Burleson. Thank you very much.

Mr. Rostenkowski. Mr. Cotter will inquire.

Mr. Cotter. Thank you very much, Mr. Chairman.

Mr. Ryan, I don't know whether you were in the audience when I questioned previous witnesses about Mr. Meany's testimony, that we are already spending some $118 billion a year, and basically the adoption of the proposal set forth by Congressman Corman would really not cost the American public any more, but would be a redistribution of the cost.

Have you any thoughts on that? It is probably very unfair to throw it at you.

Mr. Ryan. No. In fact, we have had these questions asked of us any number of times, because health insurance is an issue as much for the people within Blue Cross and Blue Shield as without.

Obviously I have a problem with that, because for the 30 years I have spent with the system, we have demonstrated that we have some expertise, ease of administration, economy of administration, and effectiveness of benefits. I am afraid when you get to an overall bill which would provide all kinds of health care, obviously it would place almost inordinate demands on the system. You would find even more inflation than we are normally experiencing so far as health benefits are concerned.

We think that within the private sector the vast majority of people have adequate coverage, that it is well and responsibly administered, and that in competition it is rated effectively. We don't see that we should set up a whole new bureaucracy and go into some uncharted fields when we have this expertise available.

As we stated in the testimony, there is a need for Government's involvement. There are certain segments of the population that we as private carriers cannot finance. But we don't think we have to revolutionize and invent a totally new system with all its problems in this area. We already have a tried and successful third party.

Mr. COTTER. You made a statement that 93 or 94 percent of the premium dollars are returned as benefits. What is your acquisition cost?

Mr. RYAN. I am not sure I can give you the exact acquisition cost, and let me explain, because you question it, the figure of 93 or 94 percent.

As you realize, I am sure, Blue Cross and Blue Shield provide joint coverage, a total program.

Mr. COTTER. How many States do they provide joint coverage in, and in how many are they separate?

Mr. RYAN. In our national accounts we can offer it in all States. In Alaska Blue Cross is covering both sides of the program. The acquisition costs are in the area of 1 percent, and they will vary from State to State. But there is a statement I would like to make concerning acquisition costs, because I think it was in the context that it wouldn't be needed in the event that a program such as Mr. Corman's came in.

Mr. COTTER. That is why I asked the question.

Mr. RYAN. A good deal less than 50 percent of the time of the Blue Cross/Blue Shield representatives is spent selling. What we have to do is educate people who already have our programs. We have servicing problems, and updating problems, and this acts for the betterment of the understanding and use of our subscribers.

No matter what program you put in, private or government, there has to be someplace——

Mr. COTTER. How about frills like advertising and so forth that could be done away with?

Mr. RYAN. It can be for the information of the subscriber.

Mr. COTTER. How many of the overhead costs can be reduced if you don't have the necessity of advertising and so forth?

Mr. RYAN. I don't think a great deal of it should be. Much of the advertising in Blue Cross and Blue Shield is really subscriber education.

Mr. COTTER. On television back in my hometown they advertise, and I know those shots go for several hundred dollars apiece.

Mr. RYAN. Blue Shield's dollar value is something like $4.5 billion, and Blue Cross is probably $8 billion.

Mr. COTTER. It is less than 1 percent?

Mr. RYAN. No doubt about that. I was talking about acquisition costs, including the 2,000 representatives on the street, and so forth.

Mr. COTTER. You make reference to the Heritage Study, and frankly I had never seen it. I was amazed at the percentage of Americans who had incurred hospital and medical expenses in excess of $5,000 a year. Is this indicative of past history as well?

Mr. RYAN. As a matter of fact, it is probably increasing, but at that point it was at 0.8 of 1 percent. There is no doubt that it is increasing.

Mr. Morris tells me that really is based on 1972 data. I would presume there would be an increase in accordance with inflation.

Mr. COTTER. This coverage up to $5,000, does Blue Cross and Blue Shield provide this in most of your policies?

Mr. RYAN. If you are talking about basic Blue Cross policies, and you will have representatives of Blue Cross, I am sure, appear before this subcommittee at a subsequent date, they do provide this coverage. In Blue Shield we are talking about anesthesia, X-ray, lab, and professional services. It is not a question of dollars, but services, right in the base contract.

Obviously hospital expenses are more concentrated, and you can get higher bills, but the techniques that are used in medicine today are expensive. You can go $1,000, $2,300 or so on a particular episode.

Mr. COTTER. Thank you. My time has expired.

Mr. ROSTENKOWSKI. Mrs. Keys will inquire.

Mrs. KEYS. Thank you, Mr. Chairman.

Mr. Ryan, the last figure I saw was a figure that showed that of the people in this country who had private health insurance only about 45 to 50 percent of them had policies which would pay anything except when hospitalized.

Do you have any idea about the accuracy of that?

Mr. RYAN. I would have to say that at this point that would be very low in my estimation. Let me take one example, because I think you are talking about ancillary services of X-ray, lab and so forth—in the doctor's office or the hospital—might not necessitate institutional care, if it is not major surgery, but it would be covered.

Over a period of, I would say, 10 to 12 years it has been an objective of Blue Shield and Blue Cross, to expand our coverage into the outpatient areas, so we would not demand that people be horizontal patients in order to receive the care.

You do have a personal choice, and not everyone sees the necessity or will accept the necessity of buying that kind of care.

Secondly, the alternative that was offered in the market, which we did not recommend, was that instead of buying the outpatient type of care on the basic coverage with full service, this be included in some of the major medical policies.

I would have to think with those, that that figure would be extremely low. If you are talking about coverage it might be true.

Mrs. KEYS. The point I am making is that it seems to me that although private health insurance has done a superb job from its instigation in helping people recognize that they can and should prepay and plan for their health needs. The system also has contributed to our delivering health in the most expensive way, and that it has not well served our people when it comes to real health care. It has been either acute care or the necessity of going into the hospital to receive even diagnostic, preventive checkups.

Do you see a remedy for that in the kind of changes you seem to wish to have made?

Mr. RYAN. I think there has been a good deal of activity within the private carriers over the period of the last 4 or 5 years in developing an alternate delivery system, for instance, so that there will be a choice among the people and, frankly, so that we can make valid comparisons between that kind of health delivery and the fee-for-service patients.

There is another aspect to this, Mrs. Keys, and that has to do with patient expectation and patient demands. There is a good deal more demand for care today, which I think we have to do something about. Perhaps it has to be done by some of the regulatory bodies. Perhaps patients have to be educated to the cost of their demands. If they use their coverage more effectively—with a certain amount of restraint—we may be able to effect more coming.

But people today are used to a system whereby they have a physician that they deal with, be it a primary physician or specialist, and it is going to be very difficult to tell people that that is not the best way for them to gain their health care.

Mrs. KEYS. I know my time is almost up. Just one more point I would like to make, Mr. Chairman.

I think people have used the only thing that has been offered to them. We have a very strong need if we are going to solve the real health problems of Americans of getting nurse practitioners and other allied health people out into the business of health education and preventive medicine. We should not insist that people come into the most expensive facilities that we have to obtain routine care. I think people are becoming more and more tired of having to wait and go through the hassle and redtape of entering a hospital.

Two other areas I am concerned about are the fact that private insurance companies have, under good actuarial statistical concepts, always had a waiting period for prenatal care. To me this is a very false idea, if we are talking about health care for Americans, because we should be concerned that every American, every child born in this country is healthy and has the best advantages.

So I think something has to be done, to get rid of any waiting period for prenatal care, and I also am concerned about the prejudice that many of the insurance companies have had in their coverage against women. The major diseases for women, which are reproductive diseases, do not have the routine basic diagnostic test, the pap smear, covered by your insurance companies.

I think something has to be done about those two things.

Mr. RYAN. We share your concern. I think if you look at Blue Shield, some of those problems do not exist in our coverage.

Mrs. KEYS. I know that is true in some cases. Thank you.

Mr. ROSTENKOWSKI. Thank you, Mr. Ryan. I will submit additional questions to you in writing.

Mr. RYAN. Thank you, Mr. Chairman.

[The questions and answers referred to follow:]

QUESTIONS SUBMITTED BY MR. ROSTENKOWSKI

Question. In your discussion of protection for the aged (pages 7 and 8), you call attention to the financial problems facing the elderly who need long-term care. I am concerned too about the problem of long-term care, but I have trouble with your argument that we should keep separate from each other the medical and nonmedical aspects of long-term care. In fact, I wonder whether, in an effective program, we would not have to deal simultaneously with both aspects. Why do you think the medical and nonmedical aspects of long-term care should be kept separate?

Answer. There are two compelling reasons to deal separately with medical and nonmedical long-term care for the elderly. One has to do with the type of facilities and personnel required; the other has to do with financing. Title XVIII is specifically (and properly) directed at the active medical treatment of patients, who happen also to be elderly. The implementing regulations concerning hospitals, skilled nursing facilities, and practitioners are all directed at paying for qualifications through which treatment may be advanced.

There is another type of care frequently needed by the elderly. It is frequently referred to as "custodial", which is an unfortunate term, but which does serve to distinguish it from active medical treatment. Custodial care, as the name implies, is directed at the basic living needs of incapacitated persons, such as feeding, dressing, bathing, and the prevention of such complications as decubitus ulcers. It is not directed at effecting cure, rehabilitation, or the palliation of symptoms.

A person who is sick and undergoing treatment has substantially different requirements from one who needs "custodial care." The staffing and facility requirements of the former are unnecessarily expensive for the latter. Worse, imposing them inappropriately could preclude the provision of services by the type of facility most available and most needed for custodial care. Kindness, cleanliness, adequacy of diet, safety, and proximity to family and friends are the major requirements of a custodial care facility. They are not, by themselves, adequate criteria for a treatment facility. On the contrary, it is our subjective impression that Medicare has separated the two types of facility to a much greater degree than existed before its passage. The distinction has been drawn precisely because the two types of facility are not interchangeable.

Secondly, it is our opinion that custodial care cannot be underwritten on an actuarial basis. This is true because the subjectivity of the factors involved in a decision to place a relative in a facility is very high, and the decision would be substantially biased, in many cases, by the availability of federal financing. The criteria for custodial care cannot be reviewed on nearly so objective a basis as a medical admission, which is in itself judgmental. Medical admission review is possible because the peer review process creates a common frame of reference. It would be almost impossible to achieve a comparable process in custodial care. In the absence of such process, the induced cost of custodial care could not, again in our opinion, be accommodated by the actuarial processes of Medicare.

As we pointed out in our testimony, this does not imply that Congress ought not to address the question of custodial care. We feel, however, that it must be addressed in the context of the welfare of the individual, and not of his health care.

Question. A major part of the coverage Blue Shield has provided through the years has been for surgical services. Some people believe that this fact has contributed to a situation in which the financial rewards for surgeons have exceeded those for other specialty groups. Now you say (at the bottom of page 3) that "the economic premium that health insurance has placed on the surgical specialties has largely been reversed. . . ." I wonder whether specialists in internal medicine and general practitioners would agree. What are the facts that cause you to find now that the economic premium placed on surgical specialties has been reversed?

Answer. The premium has not been wholly reversed, but there is a substantial trend toward a more even distribution among specialties of the health coverage dollar. This has been taking place for years, and we expect it to continue.

In mid-1975, we asked Blue Shield of Washington, D.C., to study its payments by medical specialty to assist us in understanding the trend. Blue Shield of the District of Columbia has a high proportion of subscribers in the Federal Employee Program, which provides better than average non-surgical coverage. It is not necessarily representative, although we believe that there are several Plans within Blue Shield that would show a higher proportion of total payment within the medical specialties.

In calendar 1974, the Plan's average aggregate payments per physician to specialists in internal medicine was at 89 percent of its payments per physician within a surgical category comprising neurologic, thoracic, vascular and general surgery. The finding is based on private business payments on behalf of a subscriber population representing 58 percent of the total population of the Plan's geographic area.

A similar trend is evident in a study, also of 1974 data, we ourselves conducted in 1975. We studied the general division of aggregate payments by three large Blue Shield Plans between eight specialties which typically render a large proportion of primary care and eight specialties which generally render care on referral. As the chart below shows, the primary care specialists received approximately the same aggregate payment as did the surgical specialties.

AVERAGE BLUE SHIELD PAYMENTS—1974

	Plan No. 1	Plan No. 2	Plan No. 3	Average
Primary care physicians:				
1. General practice	$5,780,986	$17,386,321		$11,583,653
2. Family practice	180,596	21,148,995	$15,219,512	12,183,034
3. Internal medicine	11,179,267	34,839,294	19,723,406	21,913,989
4. Pediatrics	1,597,582	6,387,449	3,033,156	3,672,396
5. Obstetrics and gynecology	12,654,500	28,204,742	24,707,765	21,855,669
6. Psychiatry	1,211,640	11,172,172	2,104,268	4,829,360
7. Osteopathy	32,365	14,073,588		7,052,977
8. Podiatry	2,584,443	14,550,487	3,355,257	6,830,062
Total for primary care physicians				83,771,140
Referral care physicians:				
1. Orthopedic surgery	4,009,861	12,582,796	14,504,184	10,365,613
2. Oral surgery and dentistry	1,574,954	1,518,836	9,903,358	4,332,283
3. Plastic surgery	874,950	3,354,677	2,177,523	2,135,717
4. Other surgery	8,333,585	50,604,830	39,393,422	32,777,279
5. Radiology	4,080,749	36,709,021	9,601,708	16,797,159
6. Pathology	1,239,569	11,772,031	348,652	4,453,417
7. Ophthalmology	1,069,949	3,857,546	3,396,176	2,774,557
8. Anesthesiology	1,980,809	17,003,279	9,066,538	9,350,209
Total for referral care physicians				82,986,334

Clearly, surgical and nonsurgical physicians earn their income through different combinations of price-per-service and number of services. The average price-per-service of surgery remains substantially higher than that of the average medical service, but the medical specialist is able to treat more patients. The closing of the aggregate payment gap is evidence of major improvement in the balance of health benefit packages.

Mr. Rostenkowski. Mr. Zupko, Mr. Hallett, and Mr. Reynolds.

A PANEL ON BEHALF OF THE COUNCIL OF STATE CHAMBERS OF COMMERCE CONSISTING OF JOHN M. ZUPKO, JAMES B. HALLETT, AND L. W. REYNOLDS, M.D., MEMBERS OF THE SOCIAL LEGISLATION COMMITTEE, ACCOMPANIED BY WILLIAM R. BROWN, ASSOCIATE RESEARCH DIRECTOR

Mr. Rostenkowski. Welcome, gentlemen; if you will, identify yourselves.

Mr. Zupko. Thank you, Mr. Chairman. My name is John M. Zupko. I am manager of Employee Benefits of Public Service Electric & Gas Co., Newark, N.J., but I appear here today as chairman of the Health Care Subcommittee of the Social Legislation Committee of the Council of State Chambers of Commerce. Our testimony is on behalf of the member State Chambers of Commerce of the Council, which are listed at the end of this statement as having endorsed it. Appearing with me are two members of our social legislation committee: Mr. James B. Hallett, who is second vice president of the Travelers Insurance Co., Hartford, Conn., and Dr. Lloyd W. Reynolds, who is a surgeon from Hays, Kans. Accompanying us is William R. Brown, associate research director of the Council of State Chambers of Commerce. As a member of the council's social legislation committee, I represent the New Jersey State Chamber of Commerce. Mr. Hallett represents the Kansas Association of Commerce and Industry.

In recent years the views of the council on national health insurance have been presented to the Committee on Ways and Means on three occasions: November 2, 1971, May 17, 1974, and April 3, 1975.

In testimony today, as in prior testimony, we urge your consideration of several approaches which we hope you will follow in drafting a national health insurance bill.

Mr. Hallet will proceed with our statement at this point.

Mr. HALLETT. A glance at the witness list shows that the private sector is going to be adequately defended, and a great deal of mention will be made of Mr. Burleson's bill. It therefore behooves us to be as brief as possible, and merely summarize orally, which I propose to do, without following our testimony in that order, the dozen odd points that we have. And we don't want to be guilty of the inevitable duplication of testimony which, knowing most of these witnesses today personally, I am sure that you will get.

The basic principle that we have consistently urged the three prior times that we have been before this committee is simply that we do not think Congress should throw overboard what has proved to be sound from hard won experience in the private sector, which, in the case of insurance, goes back a century in what we call modern health insurance.

This principle is old hat and it is boring to some people, but because it governs all the other parts of the structure of the legislation that you are working on, financing, administration, timing, and cost, we think it is important and has to be restated. The bills that have been before this committee in the last 5 years can easily be segregated on how much they encourage or detract from, or even destroy the private sector.

We still favor a national plan as early as possible to help fill the gaps which still exist, and there are glaring ones. We basically have and still favor Mr. Burleson's bill, which has been introduced since 1969. But the point is that the world of U.S. health care, despite all its problems, is not going to come to an abrupt end or fall apart at the seams if Congress fails to act this year, next year or the year after. Why? Because of the continuing development of the private sector, and I do not minimize the gaps that do exist, and for which we support various bills before your committee.

No one seems to have mentioned the new State interest at the State level that is going on. Twelve prestigious organizations have formed a coalition to study this matter. Some of them don't want the Federal Government or Congress to have anything to do with it. We disagree with that. We must keep peace with those organizations, and as you know, some of the States in the desperate attempt to get control, some sort of control, of hospital cost legislation, have enacted such legislation. Maryland and my own State of Connecticut have enacted legislation, and there are figures to show that since the end of controls that has been helpful to a small degree in holding down the escalation of costs. Your staff has this information.

Some States have also gone into catastrophic insurance legislation, some with an expansion of medicare, and most recently Connecticut, where, by next April, all the domestic companies and all other admitted to do business there must offer catastrophic coverage.

When we speak of coverage, we naturally support the broadest, most universal coverage that is possible consistent with cost.

We are fully aware of the need for deductibles and co-insurance to hold down costs, and this is where we limit government participation, as Mr. Burleson's bill does, to use the private sector to the maximum.

You will notice most of these groups before you are urging Government tax dollars. Mr. Rathgeber for the Health Association testified some 3.6 billion new, and 10 billion net. All these bills are costly, but mainly for health care costs of the poor, under medicaid, which Mr. Burleson's bill takes over, run by the insurance companies, the near poor, loans and grants to beef up the health care system, and bricks and mortar for the ambulatory centers and the walk-in care that Mr. Duncan and Mrs. Keys were interested in.

As far as comprehensive versus catastrophic, most major bills before you are comprehensive, and we urge that you pass a comprehensive bill.

If you are determined to pass a catastrophic-only bill, we would urge you not to follow the payroll tax route. You can give the insurance business and antitrust exemption, you can make it mandatory on employers, and you will not do harm to one of the fastest growing coverages in the country, which is the catastrophic sector.

Coverage, we think, should be available to all through certain minimum benefits offered by employers. This would be mandated by many of the bills before you.

The uninsured people, whether they can pay for it or not, and certainly if they can, should have the coverage available to them through separate pools.

May I turn, please, to mandatory against voluntary?

Many of the bills before this committee now are mandatory. Some organizations have changed, and have taken the mandatory approach. The bill we support, H.R. 5990, is still voluntary. We think that is significant, and this committee knows only too well the danger of being locked into mandatory programs. Medicare and medicaid are examples after 10 years.

We recommend voluntary for the first years. If you have to go mandatory, you will know by then. We recommended the use of tax incentives, and we have some comments on those tax incentives at the close of my presentation.

Most of the major bills before you phase in benefits. H.R. 5990 has a 2- and 10-year phase in. Because we know from experience, particularly in Canada recently, which shows us what we should not do, you phase in benefits, and the availability of care means greater utilization and greater costs.

This Congress has already taken a great many steps in various forms of legislation still in the implementing stage—HMO's, PSRO's, and more recently health planning.

Before this committee in 1971, we urged a true tax incentive. In other words, if you take away a present deduction from an employer of 100 percent of his costs for health care, and you take that away, we think that is a penalty. We urged then, and we urge now, a true incentive, 125 percent over the first year of the time that he meets the minimum standard, phased out over 5 years. This is particularly true for the smaller employer.

Financing, obviously, we have opposed the payroll tax approach in any form. Government is not more efficient, competition is very prevalent, and the Government is not now equipped through staffing or any other way to take over the administration of bills as complete a Government takeover as some that are before this committee. We urge no payroll tax approach.

Cost control is one of the most critical problems facing you, as you well know. Health care expenses have jumped from 5.2 percent of gross national product to 8.3 percent in 1975, $118 billion.

Everyone is wondering how to get a handle on that. Every one of the major bills before you has some aspect of cost control. There is much that the private insurance sector can do, there is much it cannot do, and this is where the government has to step in.

We think that both the cost control features in the Kennedy-Corman bill, and Mr. Burleson's bill, Mr. Ullman's bill, and the others have to be studied closely, but something has to be done.

I will not mention malpractice at this point, because it is clear from our statement that we urge State action and not Federal action.

Mr. Chairman, we would like now to call on Dr. Lloyd Reynolds, a practicing physician and surgeon, from Hays, Kans., from the medical viewpoint of our statement.

Dr. Reynolds. Mr. Chairman, and members of the committee, Mr. Hallett has presented the business viewpoint on the National Health bill. As a practicing physician, I have slightly different views, although I agree with him in principle.

The concept of a static health plan passed and then administered in that form indefinitely is probably desirable for your committee. You could then quit all this health insurance debate and go on to more pleasant tasks. However, National Health Insurance cannot be a static plan and requires gradual development and refinement over a period of many years and will probably never become finalized. There is no great demand or necessity for a completely locked up plan now. The concept of a one type national health insurance is not tenable.

The recently passed 1974 Public Law 93–641 health systems agencies bill, combining the Hill-Burton, regional medical program, and comprehensive health planning is now being implemented throughout all of the States. This establishes 200 to 250 local health systems divided on the basis of population, geographical areas, referral and trade patterns, and the availability of specialized physicians and trained paramedical persons, as well as adequate hospital facilities. If these plans work out, there will be a great change in the medical care delivery system and this will modify national health insurance requirements. Clearly, this is no time to become locked into a static situation since 94 percent of the employed families have private medical insurance and the retired and medically indigent are being cared for under medicare and medicaid.

Catastrophic health insurance has a great emotional appeal at the present time. The private insurance plans have been well aware of this and at the present time the great majority of health insurance policies contain provisions for this coverage after the basic plan runs out.

For example, the high quality family health plan in Kansas Blue Cross and Blue Shield charges $70 per month per family for group coverage. For $1.62 more each month an extended benefits package up to $250,000 is added. The only extra expense to the patient is a $200 deductible after the basic plan runs out, and an 80–20 percent coinsurance until a total of $200 coinsurance has been paid after which 100 percent of the medical costs are covered. For all this only a 2-percent increase in premium cost is necessary. This can be easily financed by the usual premium payment arrangements. Thus an entirely new scheme for catastrophic insurance with Federal control and with a one percent payroll tax against the employer and the employment of thousands of administrators is entirely unnecessary if the private insurance plans are allowed to continue to do a job in which they have proven their efficiency.

During the next 10–20 years we can expect moderate evolutionary changes in financing health care. Medical and hospital fees will increase due to inflation in the costs of medical supplies but principally due to the increased costs of labor. Hired labor is responsible for about 70 percent of hospital charges and about 30 percent of physicians' charges. People want more medical care and more expensive procedures and tests. The number and expense of these items will increase.

Medicare plans now cover only 52 percent of the charges for medical care for this group. The coverage will need to be increased.

The medicaid plan for the welfare group and the medically indigent under local State direction is a basically sound idea. Its administration has become a triple A headache on account of varying local conditions. Some plan of this type is needed and some good strong national administrative rules are necessary for efficient provision of medical care to this group.

The quality of medical care and hospitalization will be increasingly scrutinized. The PSRO review system, the Bennett amendment, has been accepted with some reluctance by the physicians in all but two States, but there have been so many administrative snafus, deficiencies in funding and feet dragging of the HEW department that it will be several years before this will become operative. Hopefully, these problems can be resolved in the near future. There will be increasing involvement of physicians in quality control of hospital and medical services.

The supply of physicians will probably reach demand level by 1990 according to present projections. The distribution of physicians and specialists will be influenced by the economics in each area as the saturation of physicians in the more desirable areas becomes more pronounced. Group practice in groups of all sizes will be the pattern of practice. Unless a location can support two or three physicians as a minimum, this location cannot expect a resident physician. The universal ownership of automobiles and the presence of improved all-weather roads makes a 50- to 75-mile trip in rural areas for medical care much easier than a trip across Washington, D.C. Ambulance service with trained attendants is already present in every rural county in the United States.

With more physicians available there will be less need for formally trained physician's assistants and nurse practitioners except in hospitals and physicians' offices where these paramedics work under direct M.D. control. The proliferation of partially trained individuals working independently cannot give quality medical care.

The HMO plan of medical care delivery theoretically should be more efficient in that medical care can be dispensed on a factory assembly line basis. This concept is not new and has been used in many areas especially along the west coast. Recently, its extension to every area has been advocated by my fellow citizen and friend, former Congressman Roy from Kansas. His bill requires employers to offer HMO type of health insurance as an option to the standard health insurance. The bill also sets up regulations for the organization of these plans.

Where there is a large concentration in a small area of potential HMO clients and there is an organization of physicians so that 24-hour service can be given, efficiencies are possible. A minimum of 200,000 to 500,000 clients are necessary for any real efficiency. Also the labor unions who negotiate the health plans have been reluctant to recommend HMO care in many areas since the plans limit the free choice of the physician. Probably not over 25 percent of the people will elect this type of service.

There will be limitations on the drugs that are used. Where brand name drugs and generic drugs are chemically identical, it is proposed to use the generic drugs. However, the generic drug may not be the biological equivalent of the brand name drug as shown by analysis of digitalis preparations from different drug houses. Also, generic drugs are not available where the patent rights of the brand name drug have not run out. Also, the generic drug may cost as much or more than the brand name. The administrative costs of trying to police this item will probably exceed the savings and so will be gradually abandoned.

Specialized hospital facilities such as pediatrics departments, OB departments, coronary care departments, expensive specialized diagnostic equipment such as $500,000 scanning counters in X-ray, and expensive deep X-ray therapy equipment such as cobalt units and linear accelerator machines will be placed only in hospitals where efficient use of this equipment can be made. This will be a determination made by the health service agencies in the individual health service areas.

SUMMARY

1. National health insurance is not urgently needed now.
2. A national health insurance plan is not static and requires constant change and improvement frequently.
3. Catastrophic health insurance can be provided together with basic health insurance at an increase of 2 percent in premium costs easily payable with the basic plan, no 1-percent payroll tax necessary.
4. The nationwide organization of health service agencies under Public Law 93–641 of 1974 is just being started. Revision of present national health plans should follow findings of the HSA agencies.
5. Hospital rates and physician's fees will increase due to inflation but principally due to increased labor costs as part of the inflation.
6. Medicare and medicaid plans will need revision in the next few years, especially in administration.
7. Medical care quality controls will be established. If bureaucratic inertia can be overcome, physicians will police this themselves.
8. Physicians supply will reach demand about 1990. Need for physician's assistants and nurse practitioners except under direct control of physicians will cease.
9. HMO utilization in concentrated population areas will increase but the potential is probably under 25 percent of the families.

10. Generic drug use will probably not decrease cost of drugs to any great extent.

11. Hospitals will be limited in expansion and in providing expensive specialized care unless potential efficient use can be shown.

The chairman of the committee, Mr. John Zupko, will speak as part of the summary of our testimony.

Mr. Zupko. Mr. Chairman, our summary supports the following:

1. We support broad comprehensive coverage with deductibles and coinsurance to keep down costs and help prevent over-utilization. We are against a separate catastrophic only plan.

2. We support use of voluntary approach with tax incentives, holding off the mandatory coverage until it is clearly proved that such a step is necessary. We recommend tax incentives with 125 percent deductibility of costs of minimum benefits, phased down to 100 percent over 5 years.

3. The private sector should be used to the maximum possible extent. It is proved and time tested. Government participation should be limited to situations of need.

4. There should be no payroll tax financing. The financing of benefits for the poor and the near poor should be from general revenues.

5. Health care availability and delivery should be improved by encouragement of ambulatory centers and loans and grants to the extent not already implemented by recently passed legislation.

6. The crucial question of cost control must be solved by impact of government at all levels.

This concludes our presentation.

[The prepared statement follows:]

Statement of John M. Zupko on Behalf of Member State Chambers of the Council of State Chambers of Commerce

My name is John M. Zupko. I am Manager of Employee Benefits of Public Service Electric & Gas Company, Newark, New Jersey, but I appear here today as Chairman of the Health Care Subcommittee of the Social Legislation Committee of the Council of State Chambers of Commerce. Our testimony is on behalf of the member State Chambers of Commerce of the Council which are listed at the end of this statement as having endorsed it. Appearing with me are two members of our Social Legislation Committee: Mr. James B. Hallett, who is Second Vice President of the Travelers Insurance Company, Hartford, Connecticut, and Dr. Lloyd W. Reynolds who is a surgeon from Hays, Kansas. Accompanying us is William R. Brown, Associate Research Director of the Council of State Chambers of Commerce. As a member of the Council's Social Legislation Committee, I represent the New Jersey State Chamber of Commerce, Mr. Hallett represents the Connecticut Business and Industry Association, and Dr. Reynolds represents the Kansas Association of Commerce and Industry.

In recent years the views of the Council on national health insurance have been presented to the Committee on Ways and Means on three occasions: November 2, 1971, May 17, 1974, and April 3, 1975.

In testimony today, as in prior testimony, we urge your consideration of several aproaches which we hope you will follow in drafting a national health insurance bill.

Mr. Hallett will proceed with our statement at this point.

Presentation by Mr. Hallett

OUR BASIC PRINCIPLE

There is one fundamental principle which we consider more important than any of the others related to the issue before you. We do not think Congress should throw overboard what has proved to be sound from the hard won experience of the private sector going back a century in the development of what we call modern health insurance.

It follows that the structure, experience and expertise of private competitive health insurers and private health care providers and the private practice of medicine should be used and encouraged by government to the maximum possible extent in the proper solution of the nation's health care needs.

The principle is obvious, old hat and boring to some. But it must be restated because it governs the other parts of the structure—financing, administration, timing, and cost.

Some feel that it is the division over this issue which for certainly 30 years and possibly even 60 years has kept this Committee and the Congress from passing a comprehensive national health insurance program. In the past 5 years the bills before this Committee can be easily segregated to the extent they support this philosophy or destroy it.

Wherever the truth lies, it is no doubt fortunate for the country that, during all the years that the issue has been debated, the private sector—doctors, hospitals, health insurance companies and service organizations—has kept working and competing and improving and growing so that today U.S. medical care is still the best in the world. Most families have hospital, surgical and medical insurance; more and more have catastrophic protection, dental insurance, and mental health protection; alcoholism and drug addiction are being covered. The advancement in the last 10 or even 5 years is extraordinary.

We still favor a national plan as soon as possible to help fill gaps which still exist—and there are glaring ones.

We still think that the principles and structure we support are best met by Mr. Burleson's bill which has been introduced since 1969 and which is now represented by H.R. 5990. However, we point out that the continued use of the private sector is dominant in other bills before this Committee.

The point is that the world of U.S. health care—despite its problems—will not come to an abrupt end, or fall apart, if the Congress fails to enact a full program this year, or next or the year after.

NEW STATE INTEREST

What is quite new in the last two years is activity at the state level.

Twelve (12) prestigious organizations in 1975 have formed a Coalition on National Health Insurance and are holding regional conferences to develop a statement of policy: National Conference of State Legislatures; National Governors Conference; Association of Counties; League of Cities; U.S. Conference of Mayors; Conference of City Health Officers; National Association of Insurance Commissioners; Conference of Insurance Legislators; Association of State and Territorial Health Officers; National Association of State Mental Health Program Directors; American Public Welfare Association; and National Association of State Budget Officers.

Two of these organizations want state, not federal, legislation in the future.

Two states have already enacted hospital cost control legislation—Maryland (1973), Connecticut (1974). Legislation is pending in 9 other states.

Four have enacted catastrophic insurance legislation. Arizona (being revised), Hawaii, Rhode Island (1974), Connecticut (1975, effective 4/1/76).

COVERAGE

Any legislation reported out should, we believe, provide broad comprehensive coverage as universal as possible. This is the goal of all responsible bills, but it must be tempered by the question of cost. Reasonable deductibles and reasonable levels of coinsurance are absolutely necessary to keep costs down, because cost is a combination of price and utilization.

Whether the eventual product brought out by the Committee gives greater or less recognition to the private sector as opposed to the government sector, the comparatives of arithmetic show the importance of this item especially in connection with escalating costs covered more fully below.

GOVERNMENT PARTICIPATION

Our opening words urged use of the private sector to the maximum.

We would leave the under-65 working population protected and covered by the present competitive structure of thousands of health insurance carriers and plans competing in the national market. The only stricture is that in order to get full tax deductions an employer must make available to his employees certain minimum benefits.

This means government participation should be limited to situations of need where the private sector cannot perform because the private dollars are not there.

Thus, we advocate general revenues for:

The health care costs of the poor at whatever "poverty" level Congress selects.

The health care costs of the near-poor again up to an appropriate income level to be set by Congress.

Loans and grants for education of health care delivery personnel-doctors, nurses.

Bricks and mortar for ambulatory centers to get away from the high cost of in-patient hospital care except for those who require it.

Thus, government revenues would be limited to these areas under the proposal we advance.

COMPREHENSIVE VS. CATASTROPHIC

We have long urged upon this Committee the adoption of a national comprehensive plan including catastrophic protection. The Committee is well aware of the fact that 94% of the population are now covered for some form of health insurance and 150 million people are covered by major medical (including catastrophic) health insurance which is one of the most rapidly growing forms of coverage.

We urge this Committee not to recommend passage of a catastrophic-only bill, particularly if it uses the payroll tax approach.

The Burleson bill (H.R. 5990) is a comprehensive bill and includes catastrophic protection after a $1,000 family deductible. Both the American Hospital Association's bill (H.R. 1) and the American Medical Association's bill (H.R. 6222) have catastrophic protection as well.

If it is, nonetheless, the Subcommittee's decision to report out a catastrophic-only bill, this can be done via the private sector through anti-trust protection for insurers to form regional and state pools and a mandatory program upon employers with full credit for those who have already acted. Neither government administration (or even though intermediaries), nor a 1% payroll tax are needed.

AVAILABILITY OF COVERAGE

Under the principles we espoused every employer must make available to his employees certain minimum benefits with the private market being available for greater coverage if the employer wants. Those benefits offered by the employer must include catastrophic coverage. Similarly, equal benefits must be available to those who are presently uninsurable. This question can be met by the program for pools of private carriers who, in addition to handling coverage for the poor and the near-poor using government revenues now allocated to Medicaid, will also make available to the uninsurable the qualified health plan in separate pools.

So long as an uninsured person has coverage available to him equal to the coverage of the healthier, there is no reason why he should be subsidized in any area of health insurance if he can afford it. If, of course, he falls in the poor and near-poor category, then government premiums will be used as outlined above.

MANDATORY VS. VOLUNTARY

Many of the bills before this Committee make coverage by the employer mandatory upon him. This is true whether these programs espouse the payroll tax financing route or the private sector route. We think it significant that Mr. Burleson's bill still follows the voluntary approach, although we recognize that in time and after trial the program may have to be mandatory. The dangers of being locked in, especially cost dangers, are all too apparent in Medicare and Medicaid after 10 years. What we urge now, if and when Congress adopts a national health insurance program as we have recommended, is that it start off on as flexible a basis as possible.

This can be changed if the method proposed is not proving the most efficient.

For this reason, we recommend that any national health insurance program be made voluntary for the first years and that tax incentives be used for its implementation. Any errors could quickly be corrected by Congress. This is not true of the payroll tax approach which is mandated. There is a point of no return and no change. Once committed, Congress has few if any ways to extricate itself from mistakes.

If any program is decided by you to be mandatory, no more than 50% of the burden mandated should be loaded on the employer. Any greater participation by the employer should be left to collective bargaining and if collective bargaining results in a higher percentage that is part of the better way to handle this and many other problems. Any mandatory plan also should provide for Benefit Value Equivalency. That is costs of benefits to the employer, as provided in his health benefit's plan, must equal the point value of the total benefit points in the National Health Insurance program. Under the Benefit Equivalency proposal the employer, however, would be required to provide the basic set of benefits.

PHASE-IN OF BENEFITS

Experience in this country not only with Medicare and Medicaid, but also experience in other English-speaking countries, such as Great Britain and Canada, has shown that if too much is promised to be paid for too soon, the whole system cannot bear the load. Good as our health care delivery system is in some places, it is still spotty and we recommend a very careful approach with respect to phasing in benefits to avoid excess load on the delivery system. H.R. 5990 properly has a 2- and 10-year phase-in of benefits; 1977 and 1985.

HEALTHCARE AVAILABILITY AND DELIVERY

For six or seven years this Committee has heard testimony as to gaps in health care availability and delivery, especially with respect to the cores of cities and rural areas. The existence of these gaps is, however, disputed by some. In any event Congress has responded by the passage of various forms of legislation, some of which are still in the implementing stage, such as—Eyesight, HMOs, PSROs, National Health Planning, etc.

We still think that improvement in health care availability and delivery has to be part of any national healthcare legislation to the extent not already implemented by recently passed legislation.

This Committee has long been aware of the expenses of hospital-based care. We suggest the encouragement of ambulatory walk-in centers, leaving hospital care to those cases where it is definitely needed by the advice of the physician. Provision for encouragement of ambulatory care will be found in H.R. 5990.

FINANCING

In connection with our support of the private sector to the maximum possible extent, we have long advocated against any use of payroll tax financing. The basic reasons for our opposition are well known to this Committee. Health is not wage related. In the long run perhaps Medicare financing should be taken away from the payroll tax, although we do not recommend it at this time.

That government is not as efficient an operator as private enterprise has been proved repeatedly nor is government now equipped to handle the administrative load of some of the payroll tax bills. It is not at all clear that private enterprise and the health insurance companies would be willing to act as intermediaries for a national health system to administer an approach financed by payroll taxes.

The payroll tax approach eliminates and expropriates private business to the extent of its coverage. It is worthy of note that while Congress debated pension legislation (now ERISA) there was no thought of takeover of the private sector. In the current debates over no-fault automobile insurance and federal standards for workmen's compensation we have heard no suggestions of federal takeover. Yet that is the precise effect of the payroll tax approach in the area of health insurance. A full payroll tax program such as the Kennedy-Corman bill would impact upon or terminate a half of a million jobs in the health insurance business throughout the country and more than $350 million in premium taxes to the state.

It is government takeover and a point of no return. Congress could not move back if it started that route, we believe. Our objection to payroll tax financing apply also to the Waggoner bill for catastrophic-only coverage. As noted above, this can be handled through the private sector without use of a payroll tax of even 1%. An increase of 1% is probably going to be necessary in any event by 1977 to shore up and stabilize the Social Security Trust Fund.

We support an incremental and step-by-step approach, but not via the payroll tax approach adding a little bit here and a little bit there. Experimentation should be done by the private sector which is flexible and can easily be changed, if it does not work out.

COST CONTROL

By far one of the most critical of the problems facing Congress and the country in the healthcare area is, we think, the question of rapidly escalating costs and how to get some measure of control over them. The figures are frightening and well known to this Committee.

Health care expenditures from $25.9 billion in February 1960 to $69.2 billion in February 1970, to $118.4 billion in February 1975—from 5.2% of gross national product to 8.3%.

Cost increases at a rate of 13.1 percent per year since the medical price controls expired on April 30, 1974. (National Journal, 9/20/75). In addition to deductibles, coinsurance, review of unnecessary utilization, national and state planning to avoid duplication of facilities, prospective rate review of hospitals, clinics and healthcare providers—all of which are tools in the process of keeping a lid on cost in the future—the question still remains of how to get control of cost right now. Healthcare providers are affected by inflationary pressures on everything they buy, including services. Two states have passed hospital cost control legislation (Maryland and Connecticut) which give some indication of partial success. Every one of the major bills before you has some measure of cost control in this area.

While it will, of course, not solve all the problems of inflationary pressures in the health care field, passage of a national health insurance bill of the type we recommend should go far in the right direction, especially through the planned transition from expensive hospital based in-patient care.

MALPRACTICE

The escalation of costs is further aggravated by the upswing in problems involving medical malpractice, with doctors being forced to pass on rapidly increasing premium costs to their patients as is true of any cost of doing business. It has also been charged that a great many unnecessary procedures are being ordered and paid for as a result of defensive medicine to protect the doctor from being held liable for malpractice. One of the figures cited is $2 billion a year cost for unnecessary and extra x-rays ordered.

We do not think Congress at this time should take any other action than study with respect to the malpractice problem. It is limited to a few states and a few cities. It is a tough problem but it is not now necessary to have a federal solution. We need doctors and we need to encourage young people to go into the practice of medicine.

As we have recommended that the Congress leave the regulation of health insurance at the state level, we continue to recommend also that malpractice be allowed to be solved at the state level.

TAX INCENTIVE

While we support the overall thrust of the Burleson bill (H.R. 5990), we continue to recommend a true tax incentive for this voluntary approach.

Instead of denying the employer a full 100% tax deduction of his costs if his plan does not meet minimum standards, we urge that he be rewarded for meeting the minimum requirements.

Let him deduct 125% of the cost the first year, scaled back down to 100% by the fifth year.

In 1971 (page 1196 of Part 6 of the Hearings) we indicated the extra cost to the Treasury would be in the neighborhood of $1 billion. Obviously, it would be higher now.

Even with a 125% deduction some employers would not upgrade their plans sufficiently to meet the minimum standards because of the cost increase. Since this would be the case whether the program was voluntary or mandatory, consideration might be given to use of general revenues to help these employers upgrade their plans.

Now we would like to call on Dr. Reynolds to comment on the situation from a medical viewpoint.

(Comments by Doctor Lloyd Reynolds)

SUMMARY BY MR. ZUPKO

In conclusion:

1. We support broad comprehensive coverage with deductibles and coinsurance to keep down costs and help prevent over-utilization. We are against a separate catastrophic-only plan.
2. We support use of a voluntary approach with tax incentives, holding off the mandatory coverage until it is clearly proved that such a step is necessary. We recommend tax incentives with 125% deductibility of costs of minimum benefits, phased down to 100% over 5 years.
3. The private sector should be used to the maximum possible extent. It is proved and time tested. Government participation should be limited to situations of need.
4. There should be no payroll tax financing. The financing of benefits for the poor and the near-poor should be from general revenues.
5. Healthcare availability and delivery should be improved by encouragement of ambulatory centers and loans and grants to the extent not already implemented by recently passed legislation.
6. The crucial question of cost control must be solved by impact of government at all levels.

The following State Associations have endorsed this statement:

Alabama Chamber of Commerce
Arkansas State Chamber of Commerce
Colorado Assoc. of Com. & Industry
Connecticut Business & Ind. Association
Delaware State Chamber of Commerce
Florida Chamber of Commerce
Georgia Chamber of Commerce
Indiana State Chamber of Commerce
Kansas Association of Com. & Industry
Kentucky Chamber of Commerce
Maine State Chamber of Commerce
Maryland State Chamber of Commerce
Michigan State Chamber of Commerce
Minnesota Assoc. of Com. & Industry
Mississippi Economic Council
Missouri Chamber of Commerce
Montana Chamber of Commerce
New Jersey State Chamber of Commerce
Empire State Chamber of Commerce
Ohio Chamber of Commerce
Oklahoma Chamber of Commerce
Pennsylvania Chamber of Commerce
South Carolina Chamber of Commerce
Greater South Dakota Association
East Texas Chamber of Commerce
South Texas Chamber of Commerce
West Texas Chamber of Commerce
Tenn. Taxpayers Association
Virginia State Chamber of Commerce
West Virginia Chamber of Commerce
Wisconsin State Chamber of Commerce

Mr. Rostenkowski. Mr. Duncan will inquire.

Mr. Duncan. Thank you.

I welcome you to the committee, and for your excellent presentation.

You recommend benefits be phased into the system. How long would that be?

Mr. Hallett. Until we see something better, sir, we are following Mr. Burleson's bill, and it would be about 10 years. The poor and the near-poor get it first, and then it is phased in over a period of time.

Mr. Duncan. Thank you.

Thank you, Mr. Chairman.

Mr. Rostenkowski. Mr. Burleson?

Mr. Burleson. I have no questions.

Mr. Rostenkowski. Mr. Cotter?

Mr. Cotter. Thank you very much.

I would like to welcome the panel here, particularly Mr. Hallett, who is also from my State. It seems to be Connecticut day here.

On page 9, you state that the Corman bill would impact on half a million jobs.

Mr. Hallett. This is the full impact estimated by the health association, Mr. Cotter, across the board in the country.

The impact in Connecticut, I think, is around 35,000. This is a complete takeover on the payroll tax approach. Whether those people would move with the Government——

Mr. Cotter. That is my next question.

This many people are involved in the health insurance business?

Mr. Hallett. Yes, sir, agents, company people, across the board. That is our best estimate.

Mr. Cotter. Also, Mr. Hallett, on page 5 here you mention that 94 percent of the population are now covered for some form of health insurance, by major medical. How many of these plans in your estimation are adequate?

Mr. Hallett. It depends where you sit, sir. As you know from your experience as insurance commissioner, some of them are more than adequate.

There are some plans that I think rubber workers and some of the others have, where the basic plan is such that there would be very little change made by the passage of Mr. Burleson's bill, which provides for catastrophic.

Congress itself is insured. I don't know whether you have the $250,000 limit in your plan. It is probably unlimited. My own company plan is $250,000. Many are good, and many are not too good. It is the minimum standard that we think this committee should bring forth, so that all employers must have at least a minimum, including catastrophic.

Mr. Cotter. You mention 250 million covered by some form of major medical. That would probably break out to about 60 percent of the population. Is that correct?

Mr. Hallett. I am taking the figures from the health association, and I will go back to Mr. Rathgeber's testimony again, and I am also using some National Journal figures.

They are using the word "catastrophic" to include a very broad comprehensive plan. If you want the documentation, we will supply it.

Mr. Cotter. I would. I am curious as to what coverage is being covered by the private industry and the nonprofits. This 94 percent is a high figure. I thought it was in the neighborhood of 65 to 70. Of course, I could be wrong.

If possible, if there could be a breakdown of the type of coverage which various segments of the population are enjoying, that would be helpful.

Mr. Hallett. I know there is a dispute between the health association figures and HEW's figures.

Mr. Cotter. Yes, there is, but I would like a comparative analysis.

Mr. Hallett. It is between 87 and 94 percent.

Mr. Cotter. You are right. I was wondering how many of the programs could be considered as inadequate or inferior.

Mr. Rostenkowski. Without objection, it will be made part of the record when supplied.

[The following was submitted for the record:]

Council of State Chambers of Commerce,
Washington, D.C., November 20, 1975.

Mr. John M. Martin,
Chief Counsel, Committee on Ways and Means,
Longworth House Office Building, Washington, D.C.

Dear Sir: On page 5 of the statement on national health insurance filed by the Council of State Chambers of Commerce with the Subcommittee on Health, House Committee on Ways and Means, November 7, 1975 this sentence appears:

"* * * The Committee is well aware of the fact that 94% of the population are now covered for some form of health insurance and 150 million people are covered by major medical (including catastrophic) health insurance which is one of the most rapidly growing forms of coverage * * *"

At page 319 of the transcript Representative William R. Cotter of Connecticut asked about the 94% figure and the 150 million figure. Our reply is as follows:

1. As of 1973, 182,079,000 persons has hospital expense protection—170,256,000 who were under age 65; and 11,823,000, who were age 65 and over. (Source Book of Health Insurance Data 1974–75, page 20, Health Insurance Institute, NYC).

The same chart shows that the 170,256,000 under age 65 were protected by private programs as follows:

103,918,000 by insurance companies; of which 82,272,000 were covered by group policies and 46,837,000 by individual and family policies;

72,715,000 by Blue Cross, Blue Shield and medical society plans;

8,876,000 by other plans.

Eliminating the armed forces and their dependents and institutionalized persons from the 170 million figure, means that 94% of the balance have some form of health insurance. (Testimony of Lawrence Cathles before House Ways and Means Committee, July 17, 1975, page 4).

2. "Most people already have health insurance. Well over 172 million Americans (including 12 million with coverage supplementing Medicare) have private health insurance as a result of aggressive and innovative plan design, underwriting and marketing. Some 150 million have already been provided with sufficiently adequate coverage to ease the heavy financial burden of catastrophic illness, and high limit catastrophic coverage continues to grow rapidly."

(Page 5, oral testimony before Subcommittee on Health, House Committee on Ways and Means, Health Insurance Association of America, November 7, 1975).

(See also "Private Health Insurance and the Health Care System: Problems and Solutions," September 15, 1975, The Government Research Corporation, Washington, D.C., R–359, being a memorandum furnished to Ways and Means Committee staff).

It would be appreciated if this letter could be inserted at the appropriate portion of the transcript.

Very truly yours,

William B. Brown,
Associate Research Director.

Mr. Rostenkowski. Thank you, gentlemen.

Mr. Andre Maisonpierre.

Mr. Maisonpierre. Good morning.

Mr. Rostenkowski. Welcome to the committee again, Mr. Maisonpierre. It is nice to see you again.

STATEMENT OF ANDRE MAISONPIERRE, VICE PRESIDENT, AMERICAN MUTUAL INSURANCE ALLIANCE

Mr. Maisonpierre. My name is Andre Maisonpierre.

We have a fairly extensive statement, Mr. Chairman, and would appreciate it if the statement could be made part of the record, and at this time we will proceed to summarize the statement.

Mr. Rostenkowski. Without objection, so ordered.

Mr. Maisonpierre. As property and health insurers, we have played a significant role in health care, but our role is different from that played by government in health insurance. Whereas they have been concerned with the broad spectrum of health, we have had the opportunity of specializing in trauma medicine.

It is in the role of such managers that we address ourselves to you.

We would urge the adoption of a plan based on the broadest possible access to health care as can reasonably be supported by our medical care delivery system, and to insure that such benefits are in fact made available, we would support a forcing mechanism.

Our natural distrust compulsion would lead us to suggest a voluntary program. However, we must recognize the limitations inherent in any voluntary approach. Our companies have for many years administered a variety of compulsory insurance programs, and no major complications are foreseen with a compulsory national health insurance program.

As spokesman for an important segment of the private health insurance industry, we urge a major role for private health insurers in the administration of a total health insurance program.

We recognize there are certain limitations to the private system, and that considerations might have to be given to some governmental involvement, but we are unalterably opposed to the federalization of the health insurance field.

As casualty insurers, we are concerned over potential rise in costs which could be precipitated by national health insurance. We are concerned because it will in all probability have adverse impact on our ability to exert some measure of cost control in the trauma care subsystem, our major area of responsibility in the overall health care system.

We recognize that the Health Planning and Development Act passed by the 93d Congress is intended to improve the availability and efficiency of health care services. This should reduce the pressure for cost increases in the health sector. But it will not occur overnight.

In prior appearances before the subcommittee, we have stressed support for the adoption of comprehensive health insurance, as against catastrophic health insurance programs. This position is predicated on the belief that the enactment of catastrophic health legislation would seriously fragment the health-care financing system by overemphasizing the high cost end of the health-care spectrum.

Yet, we must recognize that the failure to enact any national health insurance program is beginning to have similar effects. We are witnessing more and more pressures in Congress to develop categorical health programs such as a kidney dialysis program. These programs are not only very costly, but they also have the effect of diverting from the mainstream of health care considerable manpower and facility resources.

While we continue to support the concept of comprehensive national health insurance, and would hope that the economy would soon be able to absorb such legislation, we recognize that any further undue delay in its enactment will necessarily lead to more thoughtful consideration of legislation along the lines of H.R. 10028, which we believe would remove the need and pressures for such categorical health programs.

We believe that any national health insurance plan needs to recognize other insurance systems, to the extent that such other system play a major role as medical benefit distributors. One such system is the casualty insurance business which pays billions in medical benefits annually. These benefits finance the cost of trauma care for the industrially disabled, the automobile accident victim, the care of those who have been injured as a result of someone else's negligence.

Recognizing the inherent waste and inefficiency arising in duplication, we believe any mandatory health insurance benefits should not duplicate other Government mandated medical benefits. To eliminate such duplication, insurance benefits coverage must be made mutually exclusive of each other.

We hope to convince the committee that national health insurance should, to the extent possible, limit itself to areas not covered by other insurance systems. We think that it is of major importance to internalize the cost of insurance within definite economic units.

For example, we believe that the cost of automobile ownership and enjoyment needs to be internalized within the automobile system to include the owner's share of the economic losses suffered from auto accidents. Such internalization allows for the making of reasonably rational decisions, an important individual and public policy goal.

Similarly, we believe medical benefits paid to someone injured as a result of a faulty product should ultimately be charged to the manufacturer of that product. It should be against public policy to transfer the medical cost of injury resulting from the use of a faulty product to the health insurance policyholders themselves. Charging the product manufacturers with the cost of their negligent acts creates strong incentives for greater sophistication and care in the manufacture and design of consumer products.

As the subcommittee knows, each year almost $1 billion is paid in medical care benefits for the industrially disabled. These benefits are paid in their entirety by employers. This creates a strong incentive for the business community to develop sophisticated safety programs.

To the extent that employers provide their employees with a healthful and safe environment, the insurance costs are reduced. If workmen's compensation benefits were to be paid by a national health insurance system, not only would this incentive disappear, but employers might be relieved of the cost burden and the employee would in effect be required to pay a portion of the cost of worker's compensation benefits.

There is another important reason why national health insurance benefits should not replace medical benefits provided by casualty insurance. Casualty insurers are specialists in disability control, and amazing strides have been accomplished in the area of such control as well as in rehabilitation. Our statement cites some specific examples.

As related to worker's compensation, casualty companies have developed expertise which has resulted in their being able to manage spiraling health costs. Let me give you some proof.

The National Council on Compensation Insurance, which serves as a national statistical and rating organization for worker's compensation, reports that the average medical cost for occupational disability rose 94.8 percent from the late 1950's to 1970.

During the same period, general health care costs increased by 118 percent. This worker's compensation insurance delivered medical benefits at a cost of about 28 percent less than other health care financing systems during this period of time.

The committee should recognize hat these savings did not result from statutory percentile limitations on physicians' fees as provided in medicaid, nor did the companies have hospital cost advantages of Federal and State tax exemptions which some providers of health care benefits rely upon to compete with private insurers.

The data would indicate that casualty insurers have developed well articulated methods to control medical costs. They are designed to provide employees with the best medical care available, to minimize the cost of accidents to employers, and reduce the overall medical care loss while at the same time improving the nature of the medical care provided.

Having made the case for the need to coordinate medical benefit systems, how does one go about practically coordinating these systems?

Medical benefits paid under casualty coverage fall into two broad categories. One, benefits paid under no-fault type insurance systems, such as worker's compensation, automobile no fault, et cetera. Two, medical benefits paid under the total liability system to reimburse medical losses incurred as a result of someone else's negligence.

As related to the tort liability system, it is suggested that national health insurance be given the right to subrogate against any available tort libility benefit sources.

The subrogation mechanism is not needed, however, to coordinate national health insurance and no-fault health insurance benefits. The most widespread no-fault system in existence today is, of course, our worker's compensation system.

When this committee structured title XVIII in 1965, it recognized the need for coordinating medicare and worker's compensation benefits. The committee incorporated a provision in the law barring payment of benefits to the extent that worker's compensation benefits are also payable to the same beneficiary. This provision has worked extremely well.

The very same approach is a logical one to adopt in coordinating national health insurance benefits with other Government-mandated first party insurance programs. Foremost among these are no-fault automobile insurance plans, which more and more State legislatures are enacting today.

There is no reason whatsoever to charge the cost of no-fault automobile losses to national health insurance, and there are many reasons as cited above why the costs of these benefits should be internalized within the automobile transportation system.

Automobile no-fault insurance coverage is but one example of this new breed of insurance protection. Within the reasonable future, it is likely that a good many injuries associated with airline crashes might be handled on a no-fault basis, and it is possible that a solution to the malpractice insurance problem may call for a substantial involvement of first-party benefits in malpractice claims.

All of these no-fault benefit programs should bear the cost of the losses which they generate. These programs should not be subsidized by national health, and in fact, the limited resources available for national health insurance should be carefully nurtured so that the largest amount of benefits will be available to national health insurance for the most people at the lowest cost.

There are some who have been urging that the coordination of national health and other medical distribution systems be resolved on the basis of cost effectiveness. We would not quarrel with those who would use cost effectiveness as one of the criteria to judge which program should carry the expense. We do dispute those who use the expense markup as the measurement of cost effectiveness, or who restrict themselves to a single index for measurement.

A systems approach is the only way to measure the cost effectiveness as between medical distribution method programs. This requires a careful analysis of subsystems, including among others, loss prevention, loss cost control, and the administrative cost of benefit delivery.

Administrative expenses are not an adequate basis for judging cost effectiveness of a benefit distribution system. The objective of a system should be to minimize the loss. To the extent that an insurer can save $1 in losses by expending 50 cents in expenses, society has benefited.

Finally, we urge that to the extent it is felt necessary to impose Federal regulation on health insurance carriers, that these regulations be carefully constructed so as to neither overlap nor replace existing State property and casualty insurance regulatory programs.

In conclusion, we urge that national health insurance benefits be coordinated with casualty insurance medical benefit systems, so as to eliminate duplication of benefit payments by charging the costs on those causing the losses, thus creating a major incentive for loss control, while at the same time nurturing the limited financial resources of national health to achieve maximum coverage.

Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Thank you.

Are there any questions?

Thank you very much.

Mr. MAISONPIERRE. Thank you very much.

[The prepared statement and attachments follow:]

STATEMENT OF THE AMERICAN MUTUAL INSURANCE ALLIANCE, ANDRE MAISONPIERRE, VICE PRESIDENT

The Alliance is a trade association representing over 100 mutual property and casualty insurance companies doing business in all 50 states and the District of Columbia. A complete list of the companies is available upon request.

SUMMARY STATEMENT

General Principles.—The Alliance believes the national plan should be based on the broadest possible access to the health care system as can reasonably be supported by the medical care delivery system. The plan should be compulsory, comprehensive to include catastrophic coverages, and operated in the main, by the private insurance sector. We urge that to the extent that it is felt necessary to impose federal regulations on the health insurers, that such regulation be carefully structured so as to neither overlap nor replace existing state property and casualty insurance programs.

The Dilemma.—Although we see a need for a national plan, we are concerned over the impact of the plan on health care costs. The solution lies in a "phase-in" of benefits as the health care delivery system improves.

The Catastrophic Health Insurance and Medical Assistance Reform Act

We are concerned that a compulsory catastrophic program would lead to the channeling of already scarce medical manpower into more costly and sophisticated facilities, and thus bring about additional inflationary cost pressures on the health care delivery system. We recognize, however, that the failure to enact a comprehensive national health insurance plan creates pressures for the enactment of categorical programs which are costly, and tend to produce similar effects on the health care economy. We have reviewed H.R. 10028, and find that it is more than a catastrophic program, for it provides basic benefits for the low-income population to include the temporarily unemployed, and would encourage upgrading of health insurance generally. We feel that there is an urgent need for cost controls in the legislation, however.

We hope that the economy will soon be able to absorb comprehensive national health insurance legislation. We recognize that any further undue delay will necessarily lead to more thoughtful consideration of legislation along the lines of H.R. 10028.

Loss Should Be Charged to Source of Loss.—The Alliance believes that the economic unit in which the loss occurs, e.g. automobile ownership and operation, should be charged with cost of medical care resulting from the accidental injuries occurring within that system.

Casualty Insurance Benefits Should not be Replaced.—Casualty insurers have developed efficient procedures for controlling the costs of medical care, and at the same time assuring that the injured receives the best medical care, available. These methods have resulted from the insurers dual responsibility—the reimbursement of the medical loss, and the reimbursement of the wage loss—which creates major incentives for overall control. These incentives would no longer exist if national health insurance were to replace medical benefits provided by the casualty system.

Coordination of Benefits.—We are convinced that the casualty insurance system needs to be maintained as the primary provider of benefits for trauma care. To accomplish this purpose, it is necessary to coordinate benefits between the national health insurance system, and casualty insurance benefits. It is recommended that the subrogation procedure be utilized in the tort case, and for the first party no-fault situation that the procedures adopted by the Congress for coordinating Medicare benefits with workers' compensation be followed.

The Medicare law bars payment of Medicare benefits to the extent that workers' compensation benefits are payable.

Cost Effectiveness of Benefit Distribution Systems.—A systems approach is the only way to measure comparative cost effectiveness of benefit distribution systems. This requires more than a consideration of expense markup for other sub-systems such as loss prevention, loss cost control, and administrative costs need to be taken into account. Although casualty insurance administrative expense may be higher than health insurance, in the final analysis cost savings which tend to exceed those expenses are produced.

Conclusion.—The Committee needs to carefully weigh the impact of national health insurance on existing benefit distribution systems. National health insurance should be structured so as to coordinate benefits available under that system with existing health benefit distribution systems.

STATEMENT

On April 15, 1975, at the request of the Subcommittee on Health of the House Committee on Ways and Means, the American Mutual Insurance Alliance filed a statement setting forth its position relative to national health insurance. That statement continues to represent the Alliance basic posture on the subject.

This supplementary statement shall discuss and review important health insurance legislation recently introduced in Congress and a special study relative to the cost effectiveness of benefits distribution systems.

I. Newly introduced legislation—H.R. 10028—The Catastrophic Health Insurance and Medical Assistance Reform Act

In prior appearances before the House Committee on Ways and Means, the Alliance has stressed its support for the adoption of comprehensive health insurance as against catastrophic health benefit programs. This position has been predicated on the belief that the enactment of catastrophic health legislation would seriously fragment the health care financing system by over emphasizing the high cost end of the health care spectrum. We have been concerned that compulsory catastrophic insurance programs would lead to the channeling of already scarce medical manpower into more costly and sophisticated facilities, thus bringing about an additional inflationary cost pressure on the total health care delivery system.

Yet, we must recognize that the failure to enact any national health insurance program is beginning to have similar effects. We are witnessing more and more pressures on Congress to develop categorical health programs, such as the kidney dialysis program. These programs are not only very costly, but they also have the effect of diverting from the main stream of health care, considerable manpower and facility resources. This, in turn, has had serious effect on the total health care cost. In fact, we feel these specialized programs which respond to a particular medical condition, seriously disrupts the health care system and should, in fact, be handled within a broad national health insurance framework. It would seem that if a catastrophic health insurance plan would be enacted, the categorical health programs would no longer be needed and could be absorbed within a broader health insurance framework.

It would be wrong to consider H.R. 10028 as limiting itself to catastrophic health insurance. While this seems to be the bills' emphasis, its reach is considerably broader. Title II provides basic coverage for the low-income population and would also provide health care coverage to the unemployed, a subject which has been particularly thorny during this period of high unemployment. Additionally, we believe that Title III would encourage the upgrading of basic health insurance coverage generally.

While we feel that the enactment of national health insurance must be given primary priority, we also feel its passage without adequate health care cost controls would be totally inadmissible. Since H.R. 10028 fails to contain any cost controls mechanism, we would be much concerned that its enactment would have serious adverse effect on the total cost of health care delivery.

While we continue to support the concept of comprehensive national health insurance and would hope that the economy would soon be able to absorb such legislation, we recognize that any further undue delay in its enactment will necessarily lead to more thoughtful consideration of legislation along the lines of H.R. 10028.

II. Cost effectiveness of benefit distribution systems

In our statement of April 15th to the Subcommittee, we urged the coordination of national health insurance benefits with benefits available from other medical benefit distribution systems. Relative to the decision as to which benefit system should bear the losses, we indicated a dispute with those who use expense mark-up for the measurement of cost effectiveness or who restrict themselves to a single index for such measurement.

We have noted in the preliminary report of the HEW study, *Health Care Administrative Costs*, that its authors agree. "For purposes of discussing which form a National Health Insurance System should assure," the authors state, "it is tempting to compare the administrative cost experience of the three different entities and to make statements about their respective efficiencies and inefficiencies. We have found, however, that the commonly used measures for comparison are inappropriate and misleading if not used with extreme caution. The most common practice is to use some ratio such, as administrative expenses as a percent of premium written or earned, or administrative expense as a percent of benefits paid. In using such a ratio, the individual making the comparison implicitly assumes that the health insurance service (or the "product or output") being provided by the three major entities is homogenous. While such an assumption may be close to the truth when comparing the output of, say, differing steel companies, it is generally invalid for the service sector of the economy and for the health insurance industry in particular."

"In an actuarially "fair" world, i.e., where there were no selling costs, no administrative costs and no other services provided, on average for each individual over time," the report continues, "health premiums paid would exactly equal benefits received because the individual would be buying pure protection against the incidence of morbidity and its treatment. In a world where the individual is buying other services along with pure health insurance protection, premiums paid must be greater than benefits received on average over time. This follows because a portion of the premium must be used to pay for the other services that the individual is purchasing along with this pure health insurance protection. When statements about the efficiency of differing insuring entities are made and based on ratio comparisons, the fact that the insuring entities may be offering a variety of different services is totally ignored. Such comparisons are conceptually invalid for the purpose of comparing efficiency in delivering health insurance."

The authors see a further difficulty in the use of the above ratios, since the ratio lends itself to a type of manipulation. "In order to appreciate this fact," the report states, consider the following equation:

$$B=P-(A+C),$$

where B may represent a break-even point or a targeted level of profit, P denotes premium, A is administrative costs, and C is claims cost. Clearly, the firm can obtain a constant value for B by lowering A and increasing C by equal amounts. There are any number of reasons why an insuring organization might allow such offsetting changes. For example, the firm may find that a reduction in the claims review process, which lowers A will be accompanied by an increase in claims costs just offsetting the savings in administrative costs. Since profitability is unchanged, the firm is indifferent between the alternatives and may hope to gain consumer goodwill. Comparing the ratio A/P or A/C on a before and after basis would make the above health insuring organization appear to be more efficient after it has let A decrease and C increase, Actually, there would be no change in efficiency because its claims review function would have deteriorated, but its claims payment function expanded. Therefore, if the analyst uses ratios when comparing *different types* of health insurers, he must proceed with even greater caution."

We would point out to the Committee, that casualty insurers are different from health insurers. Casualty insurance benefits, in the main, provide coverage for trauma care, while health insurance benefits cover the broad spectrum of care. The casualty insurer also provides services such as loss-cost control and the like which are generally not provided by the health insurer. For these reasons, comparisons of the efficiences of the two as distributors of medical care benefits on the basis of expense to premium or similar ratios need to be viewed with great caution.

Conclusion

The American Mutual Insurance Alliance favors a comprehensive health insurance program based on the broadest possible access to health care as can be reasonably supported by the medical care delivery system. And to assure that such benefits are, in fact, made available we would support a compulsory program.

While we continue to support the concept of a comprehensive national health insurance program, and would hope that the economy will soon be able to absorb the impact of such legislation, we recognize that undue delay in its enactment will necessarily lead to more thoughtful consideration of legislation along the lines of H.R. 10028.

STATEMENT OF THE AMERICAN MUTUAL INSURANCE ALLIANCE TO THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, NATIONAL HEALTH INSURANCE, TUESDAY, APRIL 15, 1975

The American Mutual Insurance Alliance is the major national association of mutual property and casualty insurers. Member companies of the Alliance provide casualty coverages in all fifty states and the District of Columbia. Although casualty insurers play an important role in protecting the American consumer against medical care loss, that role is significantly different from that usually played by government and health insurers. Whereas, the latter have been concerned with the broad spectrum of health care services, casualty insurers have specialized in the area of trauma care services, and the management of that portion of the health care system. It is in this role, as specialist and manager, that we provide the following comment.

General principles

There are a number of important principles which we believe are essential to the structuring of a national health program. We would urge that the plan should be based on the broadest possible access to health care as can be reasonably supported by the medical care delivery system. And to insure that such benefits are, in fact, made available, we would support a compulsory program.

In our opinion, the national health insurance program needs to be comprehensive to include coverages for catastrophic illness or accident. As spokesman for an important segment of the private insurance industry, we urge a major role for the private insurance sector in the financing and administration of the comprehensive health insurance plan.

We recognize that there are certain limitations in the private system, however, and that consideration might have to be given to some governmental involvement. We are, however, unalterable opposed to the federalization of the health insurance field. We are aware that the adoption of a mandatory health insurance program, nanced and operated by the private sector, will probably bring with it some level of federal insurance regulation. We would urge that to the extent it is felt necessary to impose federal regulations on health insurers, that such regulations be carefully constructed so as to neither overlap nor replace existing state property and casualty insurance regulatory programs.

The dilemma

As casualty insurers, we are concerned over the potential rise in the costs of health care services which could be precipitated by a national health insurance plan. We are concerned because it will, in all probability, have adverse impact on our ability to exert some measure of cost control in the trauma care subsystem—our major area of responsibility in the overall health care system.

To us, the solution lies in a course which would phase in national health insurance as the delivery system improves under the impact of such legislation as the National Health Planning and Resource Development Act enacted by the Congress last year.

The national plan should not duplicate benefits

The National health insurance plan, in our opinion, needs to recognize other insurance systems, to the extent that such other systems play a major role as medical benefit distributors. One such system is casualty insurance which pays billions in medical benefits annually. These benefits finance the cost of medical care for the industrially disabled, the automobile accident victim, and the care of those who have been injured as a result of someone elses negligence.

Recognizing that there is inherent waste and inefficiencies in duplication, we believe that any mandatory national health insurance benefit should not duplicate other government mandated medical benefits. Without proper coordination of benefits between systems, it becomes possible for some beneficaries to receive indemnification exceeding their actual economic losses, while others may receive less. The persons receiving more indemnification may be inclined to malinger or over-utilize health care facilities, both of which have an adverse impact on costs. Further, to the extent that there is benefit duplication, there exists an overcharge for the financing of health care, an overcharge which is not economic when one considers the aggregate costs involved.

We believe that such duplications should be eliminated, and that insurance benet coverages must be made mutual exclusive of each other. We urge that national health insurance, to the extent possible, limits itself to areas not covered by other insurance systems.

Loss should be charged to source of loss

We believe it extremely important to properly assess the costs of medical care against the system where the loss occurred, and that the costs of insurance protection against these losses need to be internalized within that system.

For instance, we believe that drivers and users of automobiles should bear the cost of automobile ownership and enjoyment. Hence, there is a need to internalize the costs of automobile operation, including the owner's share of economic losses suffered from automobile accidents. Such internalization allows for the making of reasonably rational economic decisions on important individual public policy goals such as:

1. How many cars should a person own?
2. How should one vote on rapid transit issues?
3. Should a person commute by car, or is mass transportation desirable, less expensive?
4. What type or make of car should be purchased from the viewpoint of both accident avoidence and portection in the event of an accident?

Additionally, internalizing the cost of automobile accidents facilitates a generation of statistical evidence regarding traffic accidents and their causes. This, in turn, allows for the maximizing systematic approaches to traffic safety.

The need for such evidence is indicated by Title II of Public Law 92–515—The Motor Vehicle Information and Cost Savings Act—passed by the preceeding Congress.

Under the Title, DOT is required to conduct feasibility studies aimed at propagating consumer information or damaged susceptibility and crash worthiness characteristics of motor vehicles, and to include data on personal injury along with the cost of those injuries.

If national health insurance were to be made the ultimate benefit provider to auto accident victims a prime source for data on human damage-ability would no longer exist. The economic cost of automobile accidents would be diffused within the health care system and impossible to retrieve.

Similarly, we believe that medical benefits paid to someone injured as the result of faulty product should ultimately be charged to the manufacturer of that product. If health insurance benefits were to be the ultimate dispenser of benefits in this case, the cost of medical care resulting in the faulty product would not be charged against the cost of the product, but would have to be borne by all health insurance policy holders. It should be against public policy to relieve negligent entities of the cost of their negligent actions. This is particularly true when those entities are commercial enterprises. Charging them with the cost of negligent acts creates a strong incentive for the development of greater sophistication in the design and manufacturing of consumer products.

We also believe that any displacement of the workers compensation system as the medical benefit provider in industrial injury cases by a national health plan is contrary to the best interests of the worker as well as the public. Each year, over one billion dollars in benefits is paid for medical care for the industrially disabled. Since they are paid for, in their entirety, by employers, there is a strong incentive in the business community for the creation of a more healthful and safer work environment. Shifting the costs of industrial injury into a national health system would destroy this incentive, since employers would be relieved of an important cost burden which they presently shoulder. Further, it would require that the employee pay a portion of the costs of industrial accidents, a situation which we feel is clearly inequitable.

Casualty insurance medical benefits should not be replaced

Replacing medical benefits provided by casualty insurers with benefits provided under a national health insurance plan has other important implications. Although we do not know the eventual scope of national health insurance, it probably will contain madatory deductibles and co-insurance provisions in order to deter over-utilization. Except for voluntary deductibles which are beginning to emerge in some state automobile plans, casualty insurance provides first dollar medical benefits. This is especially important in workers compensation where about 25% of the cases would fall under the deductibles of most of the proposals currently under study by the Committee.

Additionally, casualty insurers specialize in the management of traumatic injury. Such injures of all types and causes constitute only about 7% of the total health care bill. It is suggested that the emphasis on trauma care management will subside if national health insurance displaces the role played by casualty insurance. National health benefit administrations will not find it economically attractive to divert substantial management functions which would have little, if any, benefit impact on approximately 95% of all of their cases. Providing benefits for trauma care constitutes the bulk—if not the totality of the casualty insurance business, and casualty insurance management has specialized in the care of trauma. It would be against the public interest to displace this specialty.

The value of this specializaton by the casualty insurer is well documented. A recent case reported in the Journal of American Insurance (see Attachment A) involved a 22 year old female school teacher paralyzed from the waist down by an automobile crash. In slightly more than five months, the teacher was back in her classroom, largely as a result of the insurers "know-how" in the coordination of her rehabilitation program.

Casualty insurance specialization in trauma care has also resulted in significant contributions in the field of physical and vocational rehabilitation. Long ago, our workers compensation insurers realized the necessity for becoming deeply committed to the rehabilitation of the industrially injured, if they were to be in a position to control disability. Not only have the companies been mass purchasers of rehabilitation services, but they have pioneered new rehabilitation techniques which greatly enhanced the opportunities for the disabled.

The emphasis on rehabilitation, however, at times overshadows other activity of the casualty insurer in trauma care. Such care involves a combination of sub-systems comprising of first aid or emergency care, definitive care, and rehabilitation. We have described above some of the company's efforts in rehabilitation. They are similarly involved in the area of definitive care.

The definitive care phase of the health care spectrum is costly since it involves high levels of physician and hospital utilization. One of our member companies, for instance, after carefully studying medical cost patterns determined that in the casualty area, it is the physician who has the greatest capability to control cost. It is his decision which determines the nature and course of treatment, the length of stay in the hospital, the days off the job, and any number of other factors which contribute to the economic impact of injury. The company therefore decided to zero in on the physician making him aware of his responsibility for cost control.

Recognizing that lecturing doctors on their responsibilities would not, in fact, get desired results, the company developed a computer data storage system permitting per case retrieval of data on individual physician experience in terms of fees, utilization of ancillary service, drug prescriptions, etc. A comparability between physicians was thus provided and deviations from the normal patterns were readily determined. Armed with this data, the company was then able to follow up with frank discussions with individual physicians of their fees and established practice patterns. The company thus went considerably beyond the computer. It combined statistical averages which machines can provide and humanized these statistics by making them apply to specific physicians.

In addition, the company hired industrial nurses, specially trained in the latest methodology of trauma care to assist physicians, in advising them of improved patient physical conditions warranting earlier hospital discharge or transfer to less costly first aid care facility, or to a rehabilitation center, or perhaps even to the patient's home. Concurrent with the nurses' efforts, the company had other employees—in their loss control departments—searching employers' job classifications for positions which injured employees might fill pending full recovery and return to former occupation.

Casualty insurance efforts to control the costs of care extends to the first aid or emergency care portion of the health care system. Although the loss range in these cases are low—less than $50.00 per case, their aggregate represents about 30% of the total insurance dollar expended for workers compensation medical benefits. Because of the nominal range of these minor accidents, companies find it difficult to control provider costs directly. The companies therefore, have followed an alternate route by educating the worker's compensation policy holders and their employees of the need to seek medical attention for any injury, no matter how slight. They found, for instance, that a three day delay between the day of the accident and first aid treatment doubled the total ultimate cost of care. Through these and other procedures the per case cost of emergency care has been reduced and for that matter has lessened the cost of insurance to policy holders.

Not only have the companies been able to control the utilization of medical care shown above, but as related to workers compensation, casualty insurance companies have demonstrated a capability to manage the costs of medical care services. Over the time span 1959 through 1969, the costs of care for the industrial injury was about 23% lower than costs reimbursed under other systems. (see Attachment B) Although similar data on the industry as a whole is not available due to time lags in the reporting system, one company's experience suggests that the situation continues. The company reported that where the Cost of Living Index for medical care services had risen 17.2% over the years 1970 through 1973, their average per case cost for workers compensation medical care had gone up only 13.4%.

We would emphasize that these savings did not result from any statutory percentile limitation on physicians fees as provided in Medicare, nor did the companies have hospital care advantages, or the federal and state tax exemptions which some other providers of health care benefits rely upon to compete with private insurers.

On the basis of the evidence, we believe it is obvious that casualty insurers have developed well articulated and smooth functioning methods to control medical care costs while insuring that the injured employee receives the best medical care available. These methods have developed out of the dual responsibility of the insurer—the reimbursement of the costs of medical care, and the reimbursement of the economic loss. Because the control of economic loss is dependent upon the nature and duration of medical treatment, there is strong incentive for the casualty insurer to organize the medical care delivery system for maximum efficiency. The replacement of casualty insurance medical benefits by national health benefits would destroy this incentive.

The dual responsibility of the casualty insurer establishes yet another reason why casualty insurance medical benefits should not be replaced by national health insurance. To discharge this responsibility, the companies have, in place, highly efficient mechanisms for handling all aspects of the trauma loss. Replacing casualty medical benefits with national health benefits would transfer responsibility for the administration of the medical loss portion to the national program. Thus, records for a single case would need to be carried in both systems with a consequent increase in administrative costs.

In our opinion, the casualty insurance system has demonstrated a capability to minimize the economic and medical loss of accidental injury for both the employer and employee. It is clear that this situation can continue only if the casualty insurer's traditional role in the management of trauma is not displaced by national health insurance. We feel that it would be against public policy to displace this role.

Coordination of benefits

For the above reasons, we are firmly convinced that, for the public good, the casualty insurance system needs to be maintained as the system with primary responsibility for the control of trauma health care. It will thus become necessary to coordinate medical benefits available under this system with those of the national health insurance system ultimately adopted.

Medical benefits paid under casualty coverages fall into two broad categories. One, benefits paid under workers compensation and no-fault systems, such as automobile no-fault. These can be readily identified. Two, benefits paid under the tort liability system to reimburse medical losses incurred as a result of someone else's negligence.

As related to the tort liability system, we suggest that national health insurers be given the right to subrogate against any available tort liability benefit sources. In our opinion, this will provide sufficient flexibility to assure that the individual receives medical care when he needs it. At the same time, through the subrogation mechanism. the ultimate cost of the care will be properly charged against the negligent party.

The procedure, of course, is not new. Most state workers compensation laws, attesting to the undesirability of duplicating tort and workers compensation benefits, provide for immediate payment of benefits following the accident. These payments, however, can be recovered through the subrogation mechanism once the tort action has been decided. The Medicaid program contains a similar mechanism, as does the CHAMPUS program of the military.

We would point out that the subrogation mechanism is not needed for the coordination of national health insurance and workers compensation or no-fault insurance benefits. In these cases, the approach developed by the Congress for the coordination of Medicare benefits with the workers compensation can be made applicable.

Medicare law bars the payment of Medicare benefits to the extent that worker's compensation benefits are also payable for the same condition. This provision in the law has worked extremely well. Beneficiaries can be paid for the cost of their medical expenses. yet the Medicare program has not been charged with any portion of the cost of industrial injuries.

We recommend that a like approach be adopted for the coordination of national health insurance benefits with other government mandated first-party insurance programs. Most prominent among these are the no-fault auto insurance plans which more and more state legislatures are enacting today. There is no reasons whatsoever to charge the cost of no-fault auto insurance medical losses to national health insurance, and there are many reasons why the costs of such losses need to be retained within the auto transportation system.

We feel it is much more logical to first exhaust first-party. no-fault automobile benefits, and then, if these benefits are insufficient, to fill whatever gaps remain through the application of national health benefits. We call your attention to the fact that the Civil Service Commission, HEW. and the Department of Transportation would also apparently agree, as do several of the states which have enacted automobile no-fault law.

We would also point out that the principle seems to be acceptable to Committee Chairman Ullman. H.R. 1, introduced by the Congressman on January 14, contains the following language in Section 123(b).

"(b) Comprehensive health care benefits shall not cover any item or service to the extent that payment has been made, or can reasonably expect to be made (as determined in accordance with regulations). with respect to that item or service under a workers' compensation law or plan of the United States or a State or under a motor vehicle insurance policy or plan. Any payment by the carrier under coverage under this title with respect to any item or service, shall be conditioned on reimbursement by the carrier when notice or other information is received that payment for the item or service has been made under such a law, policy, or plan."

And in the Senate, the following language which would amend S. 1100 (93rd Congress) introduced by Senator McIntyre.

"and any charge for any care for any injury or disease to the extent that benefits are payable without regard to fault under a coverage statutorily required to be contained in any automobile or motor vehicle liability insurance policy or equivalent self-insurance."

We strongly urge that the concepts reflected above relative to the coordination between national health insurance and workers compensation as well as automobile no-fault need to be incorporated in any national health insurance plan. But we would point out that these are only two examples. Within the reasonable future, it is likely that a good many injuries associated with airline crashes might be handled on a no-fault basis, and it is possible that a solution to the medical malpractice insurance problem may call for substantial involvement of first-party benefits in malpractice claims.

We would, therefore, urge that the coordination of benefits principles relative to workers compensation and automobile no-fault be extended to all no-fault benefit programs. These systems should bear the cost of the losses they generate. They should not be subsidized by national health insurance. Rather the limited benefits available for national health insurance should be carefully nurtured so that the largest amounts of benefits will be available for national health insurance, for the most people at the lowest cost.

Cost effectiveness of benefit distribution systems

There are some who have been urging that the coordination of national health and other medical distribution system be resolved on the basis of cost effectiveness. We do not quarrel with those who would use cost effectiveness as one of the criteria to judge which program should bear what losses. We do dispute those who use the expense mark-up for the measurement of cost effectiveness or who restrict themselves to a single index for such measurement.

A systems approach is the only way to measure comparative cost effectiveness as between medical benefit distribution methods programs. This requires a careful analysis of sub-systems, including among others:

1. *Loss Prevention. Which method is likely to generate incentives which will prevent the loss in the first instance?*

No one will argue that a system which generates incentives to prevent losses from occuring in the first place must be presumed to be more efficient than others which limit their involvement to the payment of losses once these have been incurred. We have already demonstrated that the casualty insurance system does create strong incentives to prevent losses. Incentives which would be lost if national health were to displace casualty insurers in their traditional role of medical benefit distributors.

2. *Loss cost control. Which system has demonstrated its ability to reduce and control the cost of losses?*

As has been pointed out above, the experience generated by workmen's compensation and casualty insurers in the control of medical losses has reduced the total medical cost of industrial and other casualty insurance related accidents. An insurance system must be more than a bill-paying system. It must involve itself in the development and control of cost reducing mechanisms. The casualty insurance industry is a subsystem of its own which allows for total management dedication to the care of trauma. Casualty insurers have developed expertise and sophistication which have controlled medical care costs in the trauma sub-system.

3. *The administrative cost of delivering the benefits.*

A superficial examination of the cost to deliver medical benefits between casualty and health insurers might lead one to believe that insurers are most cost-effective distributors of losses.

Administrative expenses are not, however, an adequate basis for judging the cost-effectiveness of a benefit system. The objective of a system should be to minimize the loss. To the extent that an insurer can save one dollar in losses by expending fifty cents in expenses, society has benefitted. This is exactly what is going on today. Casualty insurers' administrative expenses may be higher than health insurers' but much of the additional administrative expenses are generated to reduce the occurrence of losses and to control the cost of incurred losses. Companies maintain large staffs of trained professional engineers who continuously assist policyholders in improving manufacturing techniques, in providing safer places to work, in educating and training drivers in road skills, etc. The companies' activities to control incurred losses have already been amply described.

Conclusion

In conclusion, we would urge the Committee to carefully weigh the impact which national health legislation will have on existing benefit distribution systems.

Most importantly, we urge that national health insurance benefits be coordinated with casualty insurance medical benefits systems so as to eliminate duplication of benefit payments by charging the costs on those causing the losses, thus creating a major incentive for loss control while at the same time carefully nurturing the limited financial resources of national health to achieve maximum coverage.

ATTACHMENT A

Coordinated Care:

STRENGTH OF THE CASUALTY INSURER

Case History: How the auto insurer serves the needs of the whole person through partnership with the patient and the medical specialist.

Even before she arrived at the hospital, the young home economics teacher had begun to suspect the real extent of her injuries. Conscious, Diane Grzymko was aware she had no feeling in the lower half of her body. And because she and her husband (a high school physical education instructor) had often worked with handicapped children, Diane knew the significance of spinal cord injury.

Only minutes before she had been driving along New Jersey's Garden State Parkway when a sudden tire blowout rammed her car into a bridge abutment. No one in the car escaped injury, although John—Diane's husband—was not hurt seriously. His mother suffered severe injuries, but eventually recovered without disability. Diane, at 22, was permanently paralyzed below the waist. Hers was one of the first catastrophic injury cases to be reported under New Jersey's new no-fault benefits auto insurance law.

Because of the nature of her injury, Diane's emergency admission to the Somers Point (New Jersey) Shore Memorial Hospital was only the first step toward maximum recovery. It was May 13, 1973. Still ahead of her were more than three months of intensive medical and rehabilitative care—much of it in a facility half-way across the nation. It would

Coordinated Care: Strength of the Casualty Insurer

be a long summer, but in the end the young teacher would be prepared to continue a full and productive life, at home and in the classroom.

Diane's story is a dramatic example of rehabilitation as a people-to-people process—a blending of the efforts of the individual and her family, the medical specialist and the trained staff of the casualty insurer. Added together, these elements form a working partnership to achieve the maximum level of recovery—including, in Diane's case, a return to a rewarding professional career as a home economics teacher at the Pompton Lakes, New Jersey high school.

Because Diane sustained her injuries in a car crash, her automobile insurer (a member company of the American Mutual Insurance Alliance) did much more than just sign the checks for the $22,000 in costs associated with her accident. Since the insurer coordinates basic medical expenses with a variety of other benefits—including wage loss payments—there is a strong financial incentive to provide the injured with the very best in medical care, encouraging the fullest degree of rehabilitation in the shortest time period possible. It is this coordinated package of care that is the real strength of the casualty insurance system.

Knowledgeable people, experienced in management of traumatic injuries are employed by the casualty insurer to guide and counsel the injured, helping him toward maximum recovery. In catastrophic injury cases such as Diane's, insurance company personnel become personally involved with the patient and his family.

The person most closely involved with Diane and John Grzymko is Patricia Smith, R.N., a rehabilitation nurse on the insurance company's New Jersey professional staff. Mrs. Smith was assigned to Diane's case after early investigation by insurance representatives revealed that an injury to the spinal cord had occurred and expert guidance was needed.

Mrs. Smith arrived at the Somers Point hospital within two days of the accident. Since Diane was still in intensive care the nurse did not meet with her on the first visit to the hospital. She did, however, immediately consult with the physicians on the case to determine the severity of the injury and the quality of care the patient was receiving.

The rehabilitation nurse found that Diane was receiving excellent medical attention and that her surgeons were highly qualified. But it was clear that the young teacher also would need specialized rehabilitative service—the kind available at only a handful of facilities across the country.

Diane shows a young girl how to fold dress material according to the pattern instructions. The 22-year-old home economics teacher returned to the classroom, despite permanent paralysis resulting from a car crash.

A consulting physiatrist—a specialist in physical medicine and rehabilitation, recommended that Diane go to Craig Rehabilitation Hospital in Denver, a facility directed toward returning the spinal cord injured to as normal a life as possible. "This is where you can really help," Mrs. Smith explains. "It's not the money that is most needed—although the company will spend a great deal of money—the big thing is helping the family meet this kind of crsis, advising them where they're going to go to get the right kind of care. After all, the greatest gift you can give is the gift of independence."

The rehabilitation nurse describes Diane's case as extraordinary: "Really, she was marvelous—all of them (the family) were. It was like working with professionals. They didn't take time to feel sorry for themselves. They were sympathetic to Diane, but theirs was a constructive sympathy to assist her in the big job to be done.

"Diane herself had the perfect mental attitude. She didn't waste any time. Even before she went to Craig, while she was still at Shore Memorial, she was working with weights to use her muscles. Once, when her physical therapist was out of town for several days, John took over the therapy so that Diane would not lose her exercises."

Mrs. Smith explains the time factor is very important to rehabilitation of the spinal cord injured. "If they just lie there, infections and other problems set in. The main thing is to get them active and start physical therapy as quickly as possible."

On the advice of Mrs. Smith, Diane was transferred to Craig in Denver as soon as her condition was stabilized so that her rehabilitation treatments could begin immediately. The trip was made June 7 by air ambulance; Diane was accompanied on the flight by her husband and a Craig rehabilitation nurse. John Grzymko went to Colorado so he could work with his wife at the hospital and learn what kind of care and support she would need when she returned home.

Mrs. Smith remembers the day they left: "Diane was very popular at Shore Memorial. On the way to the airport some of us followed in a car behind her ambulance. We waited until she had boarded the plane and then we watched until the plane was a little dot in the sky."

The treatment at Craig was demanding in terms

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of both physical and psychological effort. Much of the program's success depended upon the skills of the hospital's highly trained and specialized staff. In the long run, however, it was the young teacher's personal motivation—her stubborn refusal to give up—that enabled her to return to her classroom in September when the new school year began.

"Actually she came home much earlier than the ordinary case," Mrs. Smith relates. "Diane was so anxious to begin the new school term that she didn't want to wait. She arrived home one day and began her teaching responsibilities the next."

Diane Grzymko did not allow her disability to limit her talent or effectiveness as a teacher. Today she is as deeply involved with her students as ever, often participating in after school activities as well as her regular class duties. "She's a girl of tremendous courage and great faith," says Mrs. Smith. "And everyone in the family is like that in working with her. It was really a beautiful thing to see." ☐

Auto Insurance— A Single, Reliable Source

Despite the casualty insurer's years of experience in total management of the traumatic injury case, there are some who propose splitting the basic medical coverages away from the auto insurance package.

Health plans (such as Blue Cross) now are seeking to be the primary source for auto accident medical expense payments under auto no-fault insurance laws. These plans contend that they can operate with more efficiency, thus holding down the cost.

In actual practice, however, splitting the claims payments between the casualty insurer and the health plans would result in an expensive duplication of effort in the investigation of each claim. Payment to the injured could be delayed and the overall cost to the consumer probably would increase.

On the other hand, making auto no-fault insurers the primary source of compensation for highway accident victims can result in reductions in the runaway cost of health insurance, which has been rising in cost at a rate much faster than the cost of auto insurance. In New Jersey, for example, the state insurance department recently required Blue Cross and Blue Shield to give their subscribers some $4 million in refunds and credits when the state's new auto no-fault law went into effect and auto insurers were made fully responsible for medical expenses arising from highway crashes.

Aside from the basic question of cost, it's important to consider what benefits the insurance consumer receives for each dollar he spends. Medical coverages provided under present hospitalization contracts offered by Blue Cross and similar health plans essentially are hospital coverages. By contrast, medical benefits under the casualty insurance contract provide funds for a long list of necessary auxiliary services including such items as ambulances, doctors' office calls, physical therapy, x-rays and home nursing. As an example, Diane Grzymko's insurer, operating under New Jersey's auto no-fault benefits law, provided a comprehensive package of protection against the many financial consequences of her accident.

In addition to $14,000 for medical and rehabilitative expenses, paid directly to two hospitals, Diane's policy paid $1,600 in wage loss benefits and more than $4,000 in travel and miscellaneous expenses. Included in this figure was the cost of air ambulance transportation to a specialized rehabilitation center in Denver, as well as hotel and apartment rentals for John who also stayed in Denver. Another $3,000 went for supplies and equipment; two wheelchairs were needed, one for home and one for school.

To date the casualty insurer has paid in excess of $22,000 on this claim and will continue to provide financial support for Diane's future therapy needs, which will include a return trip to Denver for further rehabilitation treatment. The company also will participate in the ongoing costs of special supplies and equipment and will pay for necessary household help.

To compare this broad package of benefits with present health plan contracts is comparing apples with oranges.

Of course, most auto crash victims do not require the extensive wage benefits and long-term medical care and rehabilitative services now available under no-fault coverages in many states. But in every accident case, the policyholder expects prompt and efficient handling of his claim—even where the only consequence is damage to his car.

In cases where more than one car is involved in the crash, the policyholder wants assurances that he will be protected against legal liability. Although no-fault laws do place limits on the driver's liability, it is not abolished entirely. In a serious accident, one where several people may be injured, the driver will need the services of trained investigators and attorneys—services which will be provided by his auto insurer.

This is the real advantage of casualty insurance—the only system which gives the accident victim a single, reliable source responding to his total needs.

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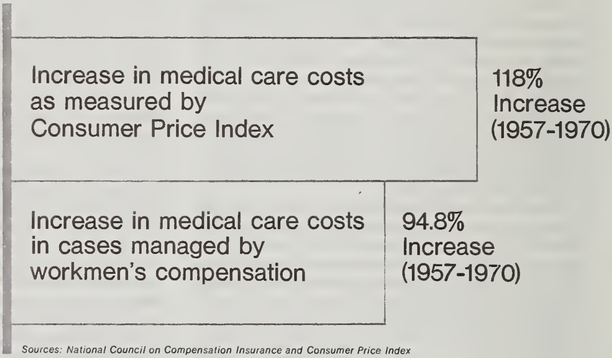
ATTACHMENT B

Here's a Cost-effective System for Managing Medical Expenses

During the decade of the 1960s, runaway inflation increased medical care costs generally by 118%. But workmen's compensation insurers held the rise in medical costs for job-related injuries to 94.8% without reducing coverages or services to the disabled.



Sources: National Council on Compensation Insurance and Consumer Price Index

Workmen's compensation holds down medical costs with good medical management practices.

A national search is now under way for ways to improve the quality and reduce the cost of medical care. In the process, workmen's compensation is emerging as a highly cost-effective system for delivering quality care to persons disabled by job-related injuries and illnesses.

It's no secret that the cost of hospital services, physicians' fees and other medical care items have soared during the past several years, exerting strong inflationary pressures on both public and private health care systems. But the most recently available data indicates that the workmen's compensation system has done a better job than most in minimizing the impact of these runaway cost increases.

The National Council on Compensation Insurance, which serves as the national statistical and rating organization for workmen's compensation, reports that the average medical cost per occupational disability case rose 94.8% from the late 1950s until 1970—from $67.65 to $131.80. The 1957-59 average was used as the base period, since this is the base period used by the U.S. Department of Commerce in its widely followed Consumer Price Index.

During the same time period, the Consumer Price Index indicates that the cost of hospital services rose 173%, physicians' fees rose 64% and all medical care costs combined rose 60%.

Data published by the U.S. Department of Health, Education and Welfare indicates that workmen's compensation medical expenses consist of 50% hospital costs, 43% physicians' fees and 7% other medical care items and services. Thus the three Consumer Price Index items can be combined into a single weighted index figure to put general medical costs and workmen's compensation medical costs on a comparable basis, as follows:

Hospital Costs	173 x .50 = 86.50
Physicians' Fees	64 x .43 = 27.52
All Medical Items	60 x .07 = 4.20
	118.22

This means that the workmen's compensation system, at the end of the decade of the 1960s, was able to deliver medical care services to persons injured in job-related accidents at a cost only 94.8% above the 1957-59 level, despite a rise of 118% in combined hospital charges, physicians' fees and other medical care expenses. That's a difference of more than 23 percentage points.

Moreover, this cost-saving feat was accomplished without skimping on service or coverage. On the contrary, the workmen's compensation system provides the most comprehensive medical coverage of any benefit system in the country. Most state workmen's compensation laws require employers to provide their employees with unlimited medical and rehabilitation services when they're disabled by an occupational injury or illness. Other medical benefit systems have dollar limits—often as low as $10,000—and don't provide complete coverage of all medical and rehabilitation expenses.

Equally important, the workmen's compensation system provides the injured worker with expert help in getting the medical and rehabilitation services he needs to make a speedy recovery and to minimize permanent impairment. It costs money to provide these expert services. But they're a bargain for the worker and for the employer alike, because they simultaneously produce better medical results and hold down the overall costs of the benefit system. ☐

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Mr. Rostenkowski. Mr. Bray, Mr. Emrick, Mr. Finnegan?

Welcome to the committee, gentlemen. If you will, identify yourselves, and proceed with your testimony.

STATEMENT OF EDWARD A. BRAY, LEGISLATIVE CHAIRMAN, INTERNATIONAL ASSOCIATION OF HEALTH UNDERWRITERS, ACCOMPANIED BY GEORGE W. EMRICK, PRESIDENT, AND ROBERT J. FINNEGAN, EXECUTIVE VICE PRESIDENT

Mr. Bray. Thank you, Mr. Chairman, and members of the subcommittee. My name is Edward A. Bray, from Chicago, Ill. I am vice president and legislative chairman of the International Association of Health Underwriters. Accompanying me are George W. Emrick, New Orleans, La., president of the association, and Robert J. Finnegan, executive vice president of the association from Wisconsin.

This appearance marks the eighth occasion, over a period of years, that we have presented our views to a congressional committee. We express our appreciation for past courtesies extended and for this current opportunity to appear. In the interest of conserving the valuable listening and reading time of this committee, we shall make this statement as succinct and concise as ability permits. In accordance with the request of this committee, I will not make a lengthy statement in support of the National Healthcare Act of 1975 embodied in H.R. 5990 as introduced by your distinguished colleague, Representative Omar Burleson of Texas. Nor shall I reiterate the principal objectives of this proposed legislation. Suffice it to say that our association herewith reaffirms its previously stated endorsement of this proposed legislation. H.R. 5990 represents, to us, the most reasoned, complete, pragmatic, fiscally responsible program to meet the health needs of all Americans.

We strongly believe the National Heathcare Act of 1975 can accomplish the goal of making quality health care, at reasonable cost, readily available to all Americans regardless of economic status or geographic location. The program will protect the interests of the economically and medically disadvantaged and at the same time preserve, strengthen, and build upon our present system of medical practice, delivery, and payment. Further, this goal can be accomplished within a framework of fiscal responsibility wherein those individuals that can afford to do so, pay a part of the cost.

There are those who advocate the imposition of a huge Government-operated bureaucracy to serve this Nation's health care. These social expansionists would tear down the private sector (here I refer to the health insurance industry), and totally fund the cost of health care through more social security taxes. How short are our memories and how fiscally irresponsible can we become? The last time around on Federal insurance was in 1966 with the inception of medicare and medicaid. Medical costs increased about 16 percent between 1965 and 1968 on the Consumer Price Index—double the rate that applied for all goods and services during that time. Over 20 million Americans now pay more in social security taxes than in income taxes and the wage base continues to be increased.

There is much current concern over a possible default by New York City on some of its bonds. It is alleged that such a default will reverberate, detrimentally, throughout the Nation. May I ask what impact you might expect if the health insurance industry is disenfranchised?—An industry that employs over a half million people and pays State premium taxes on health insurance alone that amounts to $300 million a year? Mr. Chairman, your own State of Illinois is a good example. Health insurers employ over 30,000 people in Illinois and those companies doing business in the State paid over $19 million in premium taxes on health insurance in 1972. Those are just the premium taxes. Not included are State income taxes, property taxes, and any other taxes imposed on corporations.

The health insurance industry is not without its imperfections but great strides have been made. Currently about 184 million people—about 9 out of every 10 people in the country have some form of private health insurance to help meet their medical bills. The health insurance industry has taken a prominent role to help curb the inflationary spiral of medical costs. Mechanisms of judicious claim review, utilization of paramedical personnel and active involvement in health maintenance organizations (HMO's) are illustrative of these endeavors. A recent report to the House Ways and Means Committee by the General Accounting Office confirmed that the average cost to process a medicare claim was substantially lower when done through private sector intermediaries than when processed by the Social Security Administration's Division of Direct Reimbursement.

Characteristic of the health insurance industry have been the innovative approaches to providing insurance for the ever-changing needs of the consumer. In the forefront of these endeavors have been the independent insurance agents. These are the professional men and women, numbering some 250,000 who visit across the kitchen tables, the coffee tables, and desks of America on a daily basis face to face with the consumer in helping to formulate practical solutions to insurance needs at a cost that is within reason.

These professional agents epitomize the concept of competitive free enterprise with its resultant better ideas and better ways. We just happen to still believe in the American value of self-reliance and hard work. We have not given way to the psychology of entitlement that redefines a person's "wants" into "rights."

The professional health insurance agent is an important and integral part of the American economy and the life of his community. The agent's counsel is a necessary ingredient in helping the consumer plan for his health security needs. Don't legislate that agent out of business.

We thank the committee for this opportunity to make our position known and stand ready to lend any further assistance we can as you pursue this vital issue of providing for the health care needs of the American people.

Mr. Rostenkowski. Thank you very much, Mr. Bray.

Are there any questions of the witness?

Thank you, gentlemen.

Mr. Bray. Thank you.

Mr. Rostenkowski. Mr. Arthur Mertz?

STATEMENT OF ARTHUR C. MERTZ, EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF INDEPENDENT INSURERS, ACCOMPANIED BY JOHN NANGLE, WASHINGTON COUNSEL

Mr. MERTZ. My name is Arthur Mertz. I am executive vice president of the National Association of Independent Insurers, a trade association of over 600 stock and nonstock casualty and property insurers. Our member and subscriber companies serve approximately half the automobile insurance market in this country, as well as a substantial segment of the market for other casualty insurance lines and for property insurance.

Testimony on behalf of our association concerning national health insurance legislation has been presented to the House Ways and Means Committee on two previous occasions. For this reason and in order to observe the time limitations on our presentation today, this statement will be brief. We will, however, be happy to elaborate on any particulars your committee may request, and to cooperate with the committee staff in the implementation of the general recommendations we offer here.

With me is Mr. John Nangle, Washington counsel of the association. In the interest of time, I will abbreviate my statement.

The task confronting your committee and the Congress is indeed a most difficult one. It involves a careful evaluation and weighing of the socially appealing objective of assuring the availability of quality health care for all Americans, on the one hand, against the hard realities of the need for responsible fiscal management of our Government and our economy, on the other.

While the last-named has, we know, always been an important factor in this committee's deliberations, its significance has been underscored by some of the rather frightening developments of the past 18 or 20 months on the national economic and financial scene—spiraling inflation accompanied by recessionary trends in production, employment and the securities market. Its significance has been further underscored by the tragic recent example of how fiscal laxness coupled with overindulgent welfarism have now brought this Nation's largest city to the brink of financial ruin.

More than ever before, then, social legislation however appealing from a humanitariuan standpoint must be carefully tested in terms of what we can afford—both by way of overall costs and in the context of other urgent national priorities.

No one, I am sure, is more fully cognizant of these facts and considerations than your committee. Our purpose in emphasizing them is to provide a backdrop for our recommendations to the committee.

We recommend that any national health insurance legislation that may be approved by this committee and the Congress observe the following basic principles:

It should make maximum continued use of the private, competitive insurance business as the provider of health insurance coverages, and limit Government strictly to the role of providing or subsidizing welfare-type benefits to the medically indigent where needed.

It should contain positive programs for increasing the supply and improving the distribution of quality health care in America.

It should contain provisions designed to combat runaway health-care costs and the inflationary effect that increased availability of assured benefits has often tended to have upon such costs.

In aid of the foregoing objectives and for other sound public policy reasons, it should continue to recognize and rely on the automobile insurance system and the worker's compensation system as the primary sources of compensation, respectively, in cases covered by those systems.

Let me elaborate briefly on these recommendations.

First, we are very much opposed to H.R. 21, H.R. 777, H.R. 3674 and any other measures which would make further inroads by Government—through the social security system or otherwise—into the insuring function.

Those who propose Government preemeption of any field served by private enterprise bear the burden, we believe, of establishing either that the private sector is unable or unwilling to do the job adequately, or that there are other overriding public interest considerations in the picture which clearly justify the severe economic and financial consequences that such a step involves.

Those consequences in the instant situation would include employment dislocation of hundreds of thousands of persons whose income now depends wholly or largely on the private insurance business.

We submit that no grounds exist to justify Federal preemption of all or any part of the private health insurance field, as proposed in the bills just listed. On the contrary, a very strong case can be made against such a move.

The private insurance business is a viable, progressive industry which is willing and able to fullfill the basic role of benefit-provider under a soundly conceived national health insurance program. It has demonstrated that it can execute that function more expertly, expeditiously and efficiently, and with far more personalized attention to the varied, changing needs and wants of the consumer than can a Government bureaucracy. It is therefore in the public interest for the competitive private insurance business to perform the basic insuring function under any national health insurance program.

In assigning that basic insuring function to the private insurance business, it is important that any national health legislation adopted by the Congress achieve a careful delineation and division of benefit sources between the different major lines of insurance coverage. Here, I am referring to health insurance versus casualty insurance.

The need for such delineation rests upon a number of considerations including (1) broad-scale public policy objectives, (2) the desirability of minimizing the overall cost of any national health insurance program itself, and (3) practical considerations of efficiency, convenience and consumer satisfaction in the claim processes.

First, from the broad-scale public policy standpoint, the principle is well established that to the greatest extent possible those who engage in a fundamentally dangerous or socially burdensome activity should shoulder the full costs of that activity.

It is because of this principle that our society requires the costs of compensating workers injured in industrial accidents, the costs of abating factory-produced air pollution, and the costs of paying for injuries to consumers from defective products to be borne not by the victims or by the public at large but by the enterprises whose activities create the hazards. Similarly, the principle has long been observed that motoring, which also subjects our society to serious hazards and burdens, should also pay its way to the fullest extent practicable.

Auto owners and truck owners, of course, pay the full, nonsubsidized costs of their vehicles upon purchase. Through gasoline taxes they support the cost of maintenance of the highways. And through the obligations imposed by state financial responsibility, no-fault and negligence laws, they are made to should the cost of compensating the injuries and losses inflicted in the use of their vehicles.

To so internalize costs is not only a matter of simple equity, but it also has value as a disciplinary force. If those who employ this inherently hazardous instrumentality are required to bear the entire economic and societal costs attached to its use, they will be less likely to indulge in its overuse or improper use. They (and their insurers) will also be motivated to seek and support ways of reducing the hazard of motor vehicle operations through safety measures. Conversely, if all or a significant part of those total costs are shifted away from the basic source of the problem, these important disciplinary and motivational forces will be weakened or lost.

A second grounds for the position we espouse is that keeping health care payments incident to automobile accidents and industrial accidents within the insuring systems which now cover those types of accidents will reduce the overall cost of any national health insurance program adopted. The need for exploiting every available avenue for cost cutting under social legislation is especially acute in the face of the fiscal and economic picture confronting our Nation.

As a third grounds supporting our position we submit that the benefit-paying role for automobile accident and worker's compensation cases should remain with the casualty insurance system because it has developed special experience and expertise in dealing with such cases, and because it must by necessity also continue to handle the various forms of nonmedical losses arising out of the same cases.

In the automobile insurance line, for example, the same accident which produces injuries necessitating health-care treatments usually produces collision and property damage liability claims, present and future wage loss claims, and residual bodily injury liability claims. In addition, automobile no-fault coverage, as it is now emerging, typically compensates a number of items generally outside the scope of national health insurance programs—such as survivorship benefits, funeral expenses, and certain type of residual benefits.

Shifting one fragmentary component of this bundle of claims to a national health insurance system would in no way relieve casualty insurance companies of any of their present-day obligations of investigating, verifying, processing and paying all the other many loss components arising from the same accident. Wasteful duplication of efforts by insuring systems and unnecessary inconvenience to claimants would result.

For all of the reasons cited, we urge that any legislation approved by this committee make provision that the national health insurance benefits it affords shall not be payable for any items and services if and to the extend payments are available either under worker's compensation or under a policy of automobile insurance affording direct benefits for such items and services.

In conclusion, we would state that of the legislation pending before this committee, the program we believe has the most merit is H.R. 5990, the National Health Care Act of 1975. It is designed to make quality health care available to Americans of all income levels; it would retain and build on many sound features and assets of the present system; it would maximize the role of competitive private insurance enterprises; it would emyloy, basically, a State-by-State approach to such matters as the creation of health care plans and the determination of rates; and last, but by no means least, it would provide for the continued primacy of the automobile insurance and worker's compensation systems as benefit-paying sources. This measure has our support.

In taking this position we have not failed to note that certain of the other national health bills pending before your committee also contain some (but not all) of these meritorious features. We recognize the inherent complexity of the task facing this committee and stand ready to cooperate in any way possible in further aid of your efforts to produce sound, constructive legislation in this subject area.

[The prepared statement follows:]

STATEMENT OF ARTHUR C. MERTZ, EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF INDEPENDENT INSURERS

By name is Arthur C. Mertz. I am Executive Vice President of the National Association of Independent Insurers, a trade association of over 600 stock and non-stock casualty and property insurers. Our members and subscriber companies serve approximately half the automobile insurance market in this country, as well as a substantial segment of the market for other casualty insurance lines and for property insurance.

Testimony on behalf of our Association concerning national health insurance legislation has been presented to the House Ways and Means Committee on two previous occasions. For this reason and in order to observe the time limitations on our presentation today, this statement will be brief. We will, however, be happy to elaborate on any particulars your Committee may request, and to cooperate with the Committee staff in the implementation of the general recommendations we offer here.

The task confronting your Committee and the Congress is indeed a most difficult one. It involves a careful evaluation and weighing of the socially appealing objective of assuring the availability of quality health care for all Americans, on the one hand, against the hard realities of the need for responsible fiscal management of our government and our economy, on the other.

While the last-named need has, we know, always been an important factor in this Committee's deliberations, its significance has been underscored by some of the rather frightening developments of the past 18 or 20 months on the national economic and financial scene—spiralling inflation accompanied by recessionary trends in production, employment and the securities market. Its significance has been further underscored by the tragic recent example of how fiscal laxness coupled with overindulgent welfarism have now brought this nation's largest city to the brink of financial ruin.

More than ever before, then, social legislation however appealing from a humanitarian standpoint must be carefully tested in terms of *what we can afford*—both by way of overall costs and in the context of other urgent national priorities.

No one, I am sure, is more fully cognizant of these facts and considerations than your Committee. Our purpose in emphasizing them is to provide a backdrop for our recommendations to the Committee. We recommend that any national health insurance legislation that may be approved by this Committee and the Congress observe the following basic principles:

It should make maximum continued use of the private, competitive insurance business as the provider of health insurance coverages, and limit government strictly to the role of providing or subsidizing welfare-type benefits to the medically indigent where needed.

It should contain positive programs for increasing the supply and improving the distribution of quality health care in America.

It should contain provisions designed to combat runaway healthcare costs and the inflationary effect that increased availability of assured benefits has often tended to have upon such costs.

In aid of the foregoing objectives and for other sound public policy reasons, it should continue to recognize and rely on the automobile insurance system and the workmen's compensation system as the primary sources of compensation, respectively, in cases covered by those systems.

Let me elaborate briefly on these recommendations.

First, we are very much opposed to HR–21, HR–94, HR–777, HR–2049, HR–3674 and any other measures which would make further inroads by government—through the Social Security System or otherwise—into the insuring function.

Those who propose government preemption of *any* field served by private enterprise bear the burden, we believe, of establishing either that the private sector is unable or unwilling to do the job adequately, or that there are other overriding public interest considerations in the picture which clearly justify the severe economic and financial consequences that such a step involves.

Those consequences in the instant situation would include employment dislocation of hundreds of thousands of persons whose income now depends wholly or largely on the private insurance business. Also involved would be the loss by the states of hundreds of millions of dollars in premium taxes, and the loss by the federal government similarly of substantial income tax revenues.

We submit that no grounds exist to justify federal preemption of all or any part of the private health insurance field, as proposed in the bills just listed. On the contrary, a very strong case can be made against such a move.

The private insurance business is a viable, progressive industry which is willing and able to fulfill the basic role of benefit-provider under a soundly-conceived national health insurance program. It has demonstrated that it can execute that function more expertly, expeditiously and efficiently, and with far more personalized attention to the varied, changing needs and wants of the consumer than can a government bureaucracy.[1] It is therefore in the public interest for the competitive private insurance business to perform the basic insuring function under any national health insurance program, and for the government's participation to be limited to any necessary continued subsidization of the medically indigent, a social welfare role which private industry cannot shoulder.

In assigning that basic insuring function to the private insurance business, it is important that any national health legislation adopted by the Congress achieve a careful delineation and division of benefit sources between the different major lines of insurance coverage. The need for such delineation rests upon a number of considerations including (1) broad-scale public policy objectives, (2) the desirability of minimizing the overall cost of any national health insurance program itself, and (3) practical considerations of efficiency, convenience and consumer satisfaction in the claim payment processes.

First, from a broad-scale public policy standpoint, the principle is well established that to the greatest extent possible those who engage in a fundamentally dangerous or socially burdensome activity should shoulder the full costs of that activity.

It is because of this principle that our society requires the costs of compensating workers injured in industrial accidents, the costs of abating factory-produced air pollution, and the costs of paying for injuries to consumers from defective products to be borne not by the victims or by the public at large but by the enterprises whose activities create the hazards. Similarly, the principle has long been observed that motoring, which also subjects our society to serious hazards and burdens, should also pay its way to the fullest extent practicable.

Auto-owners and truck-owners, of course, pay the full, non-subsidized costs of their vehicles upon purchase. Through gasoline taxes they support the cost of maintenance of the highways. And through the obligations imposed by state financial responsibility, no-fault and negligence laws, they are made to shoulder the cost of compensating the injuries and losses inflicted in the use of their vehicles.

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[1] The General Accounting Office, in a study prepared for this Committee, has reported that in 1973 it cost the Government nearly twice as much to process the Medicare claims handled directly by Government as it cost the four private insurance companies acting as fiscal intermediaries for the Government, and that the Government was slower in paying claims.

To so internalize costs is not only a matter of simple equity, but it also has value as a disciplinary force. If those who employ this inherently hazardous instrumentality are required to bear the entire economic and societal costs attached to its use, they will be less likely to indulge in its over-use or improper use. They (and their insurers) will also be motivated to seek and support ways of reducing the hazard of its operations through safety measures. Conversely, if all or a significant part of those total costs are shifted away from the basic source of the problem, these important disciplinary and motivational forces will be weakened or lost.

A tremendous, continuing contribution to the advancement of vehicle and traffic safety is being made by the automobile insurance industry. We have played a major role in bringing about valuable improvements in vehicle design and crashworthiness and in highway safety. Even greater future benefits are possible if our industry's basis and motivation for injury and loss reduction are not destroyed by having much of our insuring function preempted by national health insurance legislation.[2]

The basic public policy considerations which justify and necessitate continued internalization of automobile accident losses within the automobile insurance system apply equally to continued internalization of employment connected losses within the workmen's compensation system. Because that subject is being covered in considerable detail in the testimony before your Committee by other witnesses from the casualty/property insurance business, our statement will not elaborate upon it.

A second grounds for the position we espouse is that keeping health care payments incident to automobile accidents and industrial accidents within the insuring systems which now cover those types of accidents will reduce the overall cost of any national health insurance program adopted. The need for exploiting every available avenue for cost-cutting under social legislation is especially acute in the face of the fiscal and economic picture confronting the Congress and our nation.

As a third grounds supporting our position we submit that the benefit-paying role for automobile accident and workmen's compensation cases should remain with the casualty insurance system because it has developed special experience and expertise in dealing with such cases, and because it must by necessity also continue to handle the various forms of non-medical losses arising out of the same cases.

In the automobile insurance line, for example, the same accident which produces injuries necessitating health care treatments usually produces collision and property damage liability claims, present and future wage loss claims, and residual bodily injury liability claims. In addition, automobile no-fault coverage typically compensates a number of items generally outside the scope of national health insurance programs—such as survivorship benefits, funeral expenses, and certain types of residual benefits.

Shifting one fragmentary component of this bundle of claims to a national health insurance system would in no way relieve casualty insurance companies of any of their present-day obligations of investigating, verifying, processing and paying all the other many loss components arising from the same accident. Wasteful duplication of efforts by insuring systems and unnecessary inconvenience to claimants would result.

For all of the reasons cited, we urge that any legislation approved by this Committee make provision that the national health insurance benefits it affords shall not be payable for any items and services if and to the extent payments are available either under workmen's compensation or under a policy of automobile insurance affording direct benefits for such items and services.

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[2] Section 205 of the Motor Vehicle Information and Cost Savings Act adopted by this Congress in 1972 gave explicit recognition to the unique and crucial role which automobile insurers can play in gathering vital accident data relating to crashworthiness (and damageability) of different makes and models of automobiles. As the result of many months of meetings between our industry and the National Highway Traffic Safety Administration. certain of the types of data referred to in that Section are now being supplied to NHTSA, and it is contemplated that additional types of data will be furnished in the future.

As a practical matter, the kinds of vehicle accident information NHTSA needs and is requesting from auto insurers pursuant to this important statute could never be retrieved, developed or supplied by general health-care benefit providers. Were national health legislation to be adopted without preserving the primacy of automobile insurance in motor vehicle accident cases, we cannot visualize how the important obligations being shouldered by our industry under the Motor Vehicle Information and Cost Savings Act could continue to be properly and credibly fulfilled.

Conclusion

Of the legislation pending before this Committee, the program we believe has the most merit is HR–5990, the National Health Care Act of 1975. It is designed to make quality health care available to Americans of all income levels; it would retain and build on many sound features and assets of the present system; it would maximize the role of competitive private insurance enterprise; it would employ, basically, a state-by-state approach to such matters as the creation of health care plans and the determination of rates; and last, but by no means least, it would provide for the continued primacy of the automobile insurance and workmen's compensation systems as benefit-paying sources. This measure has our support.

In taking this position we have not failed to note that certain of the other national health bills pending before your Committee also contain some (but not all) of these meritorious features.[3] We recognize the inherent complexity of the task facing this Committee and stand ready to cooperate in any way possible in further aid of your efforts to produce sound, constructive legislation in this subject area.

Mr. ROSTENKOWSKI. Thank you, Mr. Mertz.

Mr. Mertz, what dollar component of your automobile policy would be attributed to health?

Mr. MERTZ. It is somewhat difficult to answer offhand, because the policy, when we talk about an automobile insurance policy, we have various mixes under the policies, of no-fault coverages, and liability coverages. I would be very glad—I would think rather than to pull a figure out of the air which, to be an average figure would be somewhat misleading, I would prefer, if we could, to submit a breakdown which would show this under a policy embodying a substantial amount of no-fault coverage, as against a policy embodying in a non-no-fault State, liability insurance.

[The information follows:]

NATIONAL ASSOCIATION OF INDEPENDENT INSURERS,
Washington, D.C., November 24, 1975.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Ways and Means Committee, Longworth House Office Building, Washington, D.C.

DEAR CHAIRMAN: In the course of Arthur Mertz's testimony for NAII on November 7, 1975, before the Subcommittee on Health of the Ways and Means Committee, you asked what component of automobile insurance would be attributable to health care. Here is the requested information for the record of the hearing.

Data derived from the July, 1970, Department of Transportation study of automobile accident personal injury claims (covering 19 states) shows the following average breakdown of the automobile *bodily injury* insurance loss dollar under the liability insurance system during the period covered by that study:

Portion of loss dollar

	Cents
Special damages:	
Medical expense	25.0
Wage loss and other specials	17.5
Total special damages	42.5
General damages	57.5
Total	100.0

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[3] H.R. 1, for example, does seek to provide a substantial continuing role for the private health insurance business, and it specifically provides that comprehensive health care benefits shall not apply to any item or service covered under a workmen's compensation law or plan or under a motor vehicle insurance policy or plan. A similar exclusion is present in H.R. 2049.

It is further to be noted that H.R. 10028, the Catastrophic Health Insurance and Medical Assistance Reform Act, in its currently pending form, reflects some improvement over its 1974 counterpart in respect of the degree of reliance on private insurance versus government insurance as benefit sources. It does not, however, contain provisions recognizing the primacy of automobile insurance as the benefit source for automobile accident claims; only workmen's compensation cases are carved out.

Under a no-fault system in which limitations are placed on recovery of general damages ("pain and suffering", etc.) the relative proportion of the total average loss dollar going for special damages and in turn, medical expenses, would increase as the proportion going for general damages decreased. How much the relative proportion of the total loss dollar going for medical expenses would increase would depend upon several factors, including (1) how severe a restriction the particular no-fault law places on recovery of general damages, (2) how effectively such restriction actually operates, and (3) the total limits of automobile no-fault medical expense coverage and wage loss coverage, respectively, called for by the law.

Yours very truly,

JOHN J. NANGLE,
Washington Counsel.

Mr. ROSTENKOWSKI. If a national health program were the prime carrier with respect to health in an accident, wouldn't that reduce the premium, or the cost of automobile insurance greatly?

Mr. MERTZ. There would be a decrease in the cost of automobile insurance, certainly, if part of the coverage were carved out, yes.

I do have doubts, however, that many of the accompanying expenses that are involved in processing the automobile insurance claims, investigation and processing, would be reduced. In fact, they could in some cases be increased by the problem of identifying how much of the collateral source benefits had been paid.

Mr. ROSTENKOWSKI. If you are going to reduce an automobile policy, you would conversely increase the cost of a national health insurance program, would you not, under those circumstances?

Mr. MERTZ. That is correct. Our position is that in choosing which of the systems should bear this cost, we would emphasize and reemphasize the fact that the automobile insurance industry, like the casualty insurance industry servicing the workmen's compensation field, have been very strong forces in the safety area, and have been motivated to do so, by keeping the costs within the automobile insurance system. We want to continue the motivation underlying those safety efforts.

Also, we have pointed out in our statement, and I don't allude to it in detail, that from the standpoint of identifying the causes of automobile accidents in relationship to, let us say, the design of automobiles, the use of safety devices on automobiles, the automobile insurance industry is the only source to retrieve and identify information of that type, and the Department of Transportation is pursuing that avenue right now.

If these costs, if this cost is shifted to a national health insurance system, it will be lost, I think, irretrievably in that system. It would be virtually impossible to identify those costs. Therefore, the safety activities not only of our industry, but I would say, of some of the governmental departments, would be undermined.

Mr. ROSTENKOWSKI. Thank you, Mr. Mertz.

Mr. Duncan?

Mr. DUNCAN. I have no questions.

Mr. ROSTENKOWSKI. Thank you very much.

Mr. MERTZ. Thank you.

Mr. ROSTENKOWSKI. Mr. Bobo.

STATEMENT OF JACK E. BOBO, SECRETARY, NATIONAL ASSOCIATION OF LIFE UNDERWRITERS, ACCOMPANIED BY WILLIAM M. BARTLETT, DIRECTOR OF HEALTH INSURANCE ACTIVITIES, AND MICHAEL L. KERLEY, COUNSEL

Mr. Bobo. Mr. Chairman, members of the committee, my name is Jack Bobo. I am an insurance agent working in Phoenix, Ariz., also currently the secretary of the National Association of Life Underwriters.

I have with me this morning two of our headquarter's staff here in Washington, our director of health insurance activities, on my right, Bill Bartlett, and our counsel, Michael Kerley, on my left.

By way of introduction, NALU is a Washington-based trade association representing approximately 130,000 life and health insurance agents, general agents and managers who live and work in virtually every community in the United States. As individual businessmen and as an association, the members of NALU have been in the health insurance business from its very inception.

Verbally, today, I would like to capsulize our prepared statement, but we would like to file for the record an expanded statement.

Mr. Rostenkowski. Your statement in its entirety, Mr. Bobo, will be included in the record.

Mr. Bobo. Thank you very much.

About 5 years ago, when the issue of national health insurance began to gain national prominence, and the debate really began in earnest, the health insurance industry was somewhat in a state of disarray. At that time, the industry had just sustained some very substantial losses, and there were many who were predicting at that time that the Government takeover of the health insurance industry was imminent, and the outlook for the future was discouraging and somewhat frustrating.

Against this backdrop, there was, of course, very little hope, or incentive for the industry to make investment.

However, in the intervening 5 or 6 years, despite the gloomy outlook at that time, in the intervening 5 or 6 years, there has been an enormous expansion of health insurance coverage, so much so that many of the statistics that were cited as being of a critical nature some years ago are no longer valid.

I refer specifically to the expansions and types of coverages that have been made generally available, particularly higher and broader coverages for the base type of coverage for the protection of people against the common, the ordinary type of illness which strikes most families.

I think significantly most policies today contain automatic escalation clauses, so that benefits automatically rise with rises in cost as opposed to the previous practice of periodic review.

Of particular interest, I believe, to the committee is the fact that most plans today have substantially higher upper limits. Many major medical policies have been expanded into the so-called catastrophic area, policies that previously provided upper limits of $10,000 to $25,000. They now go typically to $250,000 or $1 million, and the tendency to eliminate upper limits altogether is beginning to spread rather quickly.

I might add that the health insurance industry has been willing to be creative in the sense that they have experimented with alternate types of delivery systems through the mechanism of HMO's, and we have noted that there has been an increasing acceptance in recent years for coverage for dental expenses.

I think probably one of the most significant improvements in the last 5 or 6 years has gone somewhat unheralded, but nonetheless is very important, and I refer to the proliferation of multiple employer trusts, whereby very small employers, people who might employ only two or three or four people, can pool their employees in a trust arrangement whereby benefits can be achieved at a level and at a price that was formerly available only to the largest employers. So, this has made a remarkable improvement in the individual health market which was formerly, I think, the point of greatest vulnerability that our industry faced.

I would be remiss if I didn't point out that this did not take place automatically. The companies have been aggressive in the introduction of new product, but there is very little voluntary movement by the public in this area. It has been the agents working throughout the country who have convinced people of the benefits of obtaining those policies.

Despite the fact that there has been significant progress, we readily agree that health problems still exist, and many maintain we still face a health care crisis.

It is our feeling that if that crisis is to be properly addressed, there needs to be absolute clarity as to what has precipitated that crisis.

Ordinarily, in describing that, people tend to maintain that the crisis emanates from two basic areas.

First of all, people are excluded from the health system in varying degrees. This would affect between 10 and 25 percent of our population, and they are normally excluded because of geographic or economic reasons, where they are poor and/or uninsurable and cannot obtain coverage.

This is not a new problem. It is a problem that has been with us for a good many years, and I think that any objective study today would reveal that we probably are doing a better job in that dimension of the problem than we have at any period in history.

Cost represents the second part of the problem and this affects everybody, and, of course, to the extent that it has been escalating in the last several years, it is a new problem. I think that any real study of the crisis would have to conclude that the real precipitator of the crisis that we face today is cost, and our great fear is that if this is left uncontrolled, there will be more and more people excluded from the system, primarily coming from the middle economic sector.

So, we agree that the problems are real and that a solution is needed.

It is our position that adequate health care is a right more so than a privilege, but we do not believe that a national health insurance program that simply substitutes a social system for the private one already in place is the best way to guarantee that right.

The problems that affect the crisis are diverse and complex, and the substitution of a government financing mechanism we do not believe would correct the ills. In fact, it could very well aggravate the problem.

We foresee a broader approach, one that attacks the right causes, for our concern would be that government financing would simply provide temporary insulation against the problem while the problem itself continued to grow.

It is for that reason that NALU supports H.R. 5990, the Health Care Act of 1975, which was, of course, introduced by Congressman Burleson of this committee, and cosponsored by Mr. Duncan.

The details of this act have already been covered by previous testimony, and it is contained in our written statement, so we will pass over that for the moment, and simply make one additional observation.

Many people have described today our health-care delivery system as a patchwork, and I have to admit that if you took a look at it in the overall, that probably would be an adequate description and probably an accurate one, but I think in describing it as such, it should be borne in mind that a health-care delivery system and the health insurance mechanism in particular is a function of its environment.

In other words, we have the kind of system we have because of what we are, because of the kind of society that we have, just as the people of Western Europe have the kinds of systems that their social fabric would dictate.

The truth is, when you look at our population in the United States, we have a population patchwork as contrasted to the rather homogeneous types of populations of the countries of Western Europe.

Our patchwork population is used to choices. It likes the idea of freedom of choice, and in many instances, it is required to have the choices of a pluralistic system to approach the solutions to the problems it faces.

But, we do not believe that a social health insurance system necessarily represents the next step up the evolutionary ladder. We would say it is particularly true today, when our resources are strained at all levels, strained to give the benefits that they were designed to give within our ability to pay for them.

So, we would urge the Congress not to dismantle the present system, but rather to look favorably on H.R. 5990 as the best available method to build on our present strengths in order to guarantee the health-care rights of all citizens.

Again, we thank you for this opportunity to update our point of view and to appear before you this morning.

Mr. Rostenkowski. Thank you, Mr. Bobo.

Throughout your statement, you referred to measures to control costs as being a most important factor. To what extent would you say that the insurance industry has contributed to those present high costs?

Mr. Bobo. I think this was referred to somewhat earlier in questions directed by Mrs. Keys. I think it was a valid criticism of the insurance industry in the past, that oftentimes we covered various types of procedures if a person were in the hospital, but it was not covered outside the hospital. It has had a tendency to force people into the hospitals in order to obtain the financing for these kinds of services.

I believe that is a practice which has largely been discarded by the industry. Services like preadmission testing have come upon the scene which are carried out prior to going into the hospital, and are fully covered.

Several States have passed laws prohibiting this kind of practice, and I think perhaps that we were guilty in the past, but I would have to plead not guilty today.

I think there is probably one other dimension to that question. For many years, the only notice that the public had that health-care costs were rising was a very small increase in their health insurance premiums, and in effect, I think we insulated the public from what was really going on in the health-care field, and so there was no attention given to their appetite for health-care services.

It wasn't until the last several years when these increases have been in such enormous leaps that the public has become aware that health-care costs have been escalating very steeply, and that is when the public cry went up.

I think the insulation that we provided probably should have been accompanied by better information as to what was taking place.

Mr. Rostenkowski. Do you believe, Mr. Bobo, that the insurance industry has done enough to control costs?

Mr. Bobo. Well, the insurance industry, of course, was never delegated any statutory authority to do that.

Mr. Rostenkowski. It is an in-house operation, isn't it?

Mr. Bobo. Yes.

The insurance industry has instituted procedures and policy provisions which we feel have done a great deal to hold down costs. The introduction of deductibles and coinsurance features, of course, have been cost-control measures. We have gone in many instances, where costs were unreasonable, to peer review in order to establish the level of benefits to be paid.

But I think there is a limit under present arrangements to what industry can do, but we have attempted to do what could be done within the limit of our authority.

Mr. Rostenkowski. Mr. Duncan will inquire.

Mr. Duncan. Mr. Bobo, do you think the private insurance industry can administer a national health insurance program at less cost than the Federal Government?

Mr. Bobo. It would be my personal belief that that would be true, and I believe that there is some evidence to support that belief in recent reports that have been released by the General Accounting Office.

Mr. Duncan. I want to thank you for your presentation. As usual, your group has always given one of the best presentations to this committee on matters of health, and also to compliment you on your Washington staff. They are very effective and very good advocates of your cause.

Thank you very much for being here.

Mr. Rostenkowski. Mr. Corman will inquire.

Mr. Corman. Thank you, Mr. Chairman.

If we could pursue the chairman's line of questioning a minute, I would say I feel less insulated every year.

If we move to some kind of compulsory private insurance system, do we not have to get some kind of price control on health deliverers? You do not have any ability to do it. You have to pay 80 percent of whatever the bill is, and as the bills go up, you have to increase the premium. You cannot do anything else.

Now, should we arm you with the capacity to negotiate with the doctors, to keep prices down, or should we do something. I must say, if I am paying 100 percent, there is more pressure on my part to keep the fee down. But, if I am paying 20 percent and you are paying 80 percent, what do we do in that respect?

Mr. BOBO. Well, I think coinsurance is an effective mechanism in small claims, and does join the consumer in the battle to hold prices down. I expect you wanted to pursue that.

Mr. CORMAN. When I pay 20 percent, and something that would cost $50 or $100 only costs me $10 or $20—I realize that the premium will go up later, but right now I want to see the doctor, if he will see me.

Mr. BOBO. I think the insurance company has a responsibility, and I think the patient has a responsibility. The providers of services, however, have always taken a dim view of being dictated to by the insurance companies in terms of what is paid, so I think the insurance industry would be much more comfortable with some kind of external mechanism such as a PSRO or some kind of a board that would act as an intermediary to settle these price disputes.

Mr. ROSTENKOWSKI. Thank you, Mr. Bobo.

Mr. BOBO. Thank you, sir.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS, JACK E. BOBO, CLU, SECRETARY

INTRODUCTION

Mr. Chairman, my name is Jack E. Bobo, CLU, Secretary of the National Association of Life Underwriters (NALU). I am happy to appear today on behalf of the Association and present its views on National Health Insurance.

By way of introduction, NALU is a Washington based trade association representing approximately 130,000 life and health insurance agents, general agents and managers who live and work in virtually every community in the United States. As individual businessmen and as an association, the members of NALU have been in the health insurance business from its very inception. Most of the individual health insurance plans underwritten by insurance companies, and many of the group health insurance plans, are sold through the efforts of our membership. Because of their many personal contacts with consumers, life underwriters have become intimately acquainted with and sensitive to most of the problems which our currnt healthcare system poses for the public. It is our purpose here today to suggest remedies which we believe the public wants and needs, and make recommendations which will help the system perform its function better for all the people.

STRENGTHS OF PRESENT SYSTEM

Before reciting some of the shortcomings of our healthcare system, perhaps it would be appropriate to acknowledge for a moment that there are many things right with it. It seems to be a very popular pastime to castigate the system, but the fact is that for a great majority of our population our healthcare system does an excellent job. The brilliance of American medicine has lead to the conquering of dreaded diseases and has produced the technology whereby the American public could be the healthiest in the world.

The basic problems with our system, as we see it, are that not everyone can share in its benefits, and services are not always available for all persons when needed. The reason for these problems are complex and involve more than just the insurance mechanism or the medical personnel involved in the system. We believe that all elements of the system, medical, hospital, supplies, political administration, the insurance industry, and public attitudes share in the responsibility for the system's shortcomings.

NALU'S BASIC POSITION

NALU's appearance here today marks the third time that we have testified before the Committee on Ways and Means on the subject of national health insurance, although it is a first for us before the Subcommittee on Health. On each prior occasion NALU has recommended that if this country is to have any affirmative policy on national healthcare, it should be one which would blend the capabilities of the private health system with the unifying force of the Federal Government. Such a partnership, we believe, would result in a distribution of healthcare benefits to the entire population without destroying those portions of the system which are performing excellently. We repeat that call, today.

A FEDERAL ROLE WITH LIMITATIONS

The following factors seem to call for a Federal role in finding solutions to the Nation's healthcare problems:

1. There is strong and growing pressure to create some form of a national, as opposed to state-by-state, healthcare policy;
2. State-by-state solutions should be avoided. Individual action by the states might create a multitude of separate approaches to a single problem thereby further complicating the problem;
3. The entire healthcare system needs to be examined and not merely its financing mechanism; The Federal Government seems to be in the best position to carry out such an inquiry;
4. The incentives that may be created at the state level (such as tax deductions) do not provide sufficient motivation for employers and individuals to voluntarily broaden health insurance coverages. Federal tax incentives would support voluntary efforts to purchase broadened health insurance.

While the situation seems to call for Federal leadership in solving our national healthcare problems, by no means do we believe that the solution should be solely a Federal one as recommended by some parties to the national health insurance debate. Several recent revelations point to the reason. A September 30, 1975 Report by the General Accounting Office to the Committee on Ways and Means comparing the performance of private fiscal intermediaries with that of the Social Security Administration in handling Medicare claims reveals that all the private organizations considered in the report outperformed Social Security by a substantial margin. Recent newspaper reports centering on the Social Security Administration's management of the Supplemental Security Income program uncovered huge errors which have cost the taxpayers millions of dollars. There have been similar reports of high error levels in the food stamp program. We believe the GAO Study, the SSI problems and food stamp miscues point out that government does indeed have limitations in its abiilty to solve problems and administer new programs on a monolithic basis. In the words of Social Security Commissioner James B. Cardwell "(W)e ought to be very careful in assigning further roles to the Federal Government because the Federal Government is not omnipotent as some would have us believe". We believe that Commissioner Cardwell has not understated the case.

Though government does have its limitations, it does not mean that if we are to have a national health insurance program the Federal Government should not have a significant role to play. What we favor is a national policy established by the Federal Government which builds on our present system, but would not amount to a nationalization of the healthcare industry. We advocate a partnership—not a sole proprietorship.

PRESENT SHORTCOMINGS

What are the areas of greatest needs in our healthcare system? NALU believes that the present shortcomings in our healthcare system stem from six basic sources, a maldistribution of current resources, including personnel and facilities; the difficulty some people have in gaining access to adequate medical services; poor health caused by other than medical reasons such as failure to seek medical care, poor diet, poor personal health habits and environmental factors; the escalating costs of healthcare; a heretofore lack of overall coordinated planning in allocating current resources and creating new ones; and a lack of sufficient healthcare personnel of all tyes. Obviously, not all of these factors are controllable by the health industry or government, particularly those contributed by individuals themselves. But most of the shortcomings can be improved, and we would like to express our views on those.

MONEY AS A BAR TO ACCESS TO HEALTHCARE

While lack of access to adequate healthcare often stems from nonexistent or overcrowded facilities and overworked personnel, lack of money looms large as a major factor in non-accessibility. Often times it is not only the non-working poor who have problems. Such groups without access include people who are working but who cannot afford to buy private health insurance. It also includes those who cannot obtain insurance because they are uninsurable for one reason or another or can only purchase health insurance at very high rates.

RISING COSTS

For the great majority of the public that does have comprehensive health insurance and access to adequate medical facilities, spiraling costs represent the greatest problem. Daily life underwriter contacts with consumers indicate that for the general population medical costs and therefore insurance costs have gotten out of hand. Unfortunately, just because we pay more for health services does not necessarily mean we are getting more healthcare. It often means we are merely paying more for the same services.

It is NALU's view that healthcare costs must be stabilized as soon as possible. NALU believes that controlling costs will only be possible by addressing most of the other problems in the system at the same time. So, when we talk of controlling the cost of healthcare, we are really talking about solving most of the problems of the healthcare system.

LACK OF HEALTHCARE SERVICES

The nonexistence or unavailability of needed healthcare services is a vexing problem for a significant segment of the population. Nonexistence or unavailability of desired health services results from two causes: inadequate number of healthcare facilities and personnel, including doctors, nurses, technicians and the many other diciplines associated with the medical profession, and their lack of even dispersal throughout the geographical areas of need. We need, obviously to increase the total number of healthcare personnel and facilities and improve their distribution.

PLANNING

Rising costs, inadequate numbers of healthcare personnel, and maldistribution of available health resources really point to another failing of our healthcare system, a heretofore lack of central planning and coordination. While many states and local communities have healthcare agencies which are responsible for planning facilities and services, it is apparent that their combined efforts have not solved the problem. Recent studies indicate that there are still many communities which have too many hospital beds, equipment, and medical professionals, while others go begging. At some point these resources must be distributed on a rational, evenhanded basis if quality healthcare is to become available for all the people.

LACK OF HEALTH INSURANCE AS BAR TO HEALTHCARE SERVICES

Finally, some people are unable to gain access to the healthcare system because they do not have the money to buy their way into the system either by paying for needed services out of pocket or by purchasing insurance beforehand. Some poor or near poor people cannot see private doctors or use private facilities, and so seek help from public clinics which are over burdened and cannot carry the load. Some of these individuals seem to simply give up in frustration and do without the services needed. Some other people, even though not poverty stricken, have a similar problem in that they are uninsurable or can only acquire insurance at very high rates. These are the very people who are most likely to need medical services since uninsurability and sometimes poverty are often a result of major illness or injury. In any event, except for routine medical service, a lack of insurance often bars a poor or uninsurable person from receiving needed but expensive medical care.

Financing of medical benefits is the area for which the insurance industry is most responsible and in which it has the most expertise. It has been alleged by proponents of measures designed to supplant the insurance industry in the healthcare system that the industry is one of the primary causes of all the other shortcomings of the healthcare system, too. While we do not accept that charge, we do acknowledge that the insurance industry is being expected to assume a larger responsibility in the overall scheme of things. particularly in areas relating to cost of doctor and hospital services. The industry lacks any legal hardware to directly control costs contributed by the other segments of the system or realign the way care is delivered, but it is well aware how the financial structure interplays on these other factors.

Even though the health insurance industry cannot unilaterally control all costs directly it can and is trying to improve the accessibility of all segments of the population to quality healthcare. This involves first making quality health insurance products available to the public at prices which are reasonable in relation to the risk. But, making a product available to the public is only half the job. There is no compulsion on the part of any member of the public to buy it, and this is one of the areas where the agent plays a significant role.

It is the agent most often who initiates the contact which transmits the knowledge that a product exists which will satisfy the health insurance needs of an individual or business. It may seem strange to the uninitiated that many people have to be "sold" something which they need. But, whether it be an individual who has no access to a group plan, or a business which could afford the relatively small cost of increasing, say to $250,000, the catastrophic illness benefit which is already a part of an existing basic health plan for employees, our members find that it cannot be taken for granted that needed coverage will be acquired. But, all segments of the insurance industry including agents have been making a major effort over the last several years to make needed coverage available and convince the public that it should acquire it. Latest industry figures indicate that these efforts are paying off. More Americans are now covered with better health insurance providing higher limits than ever before.

THE RIGHT TO QUALITY HEALTHCARE

But, while the present system is doing a good job for a great majority of the population, it can and must do better. NALU is now persuaded that access to quality healthcare should be in reach of all persons and might properly be included among other, more traditional individual rights. As stated above, though, we do not believe this access should not be guaranteed at the cost of nationalization of the health insurance industry or any other portion of the healthcare system. Fortunately for us and the Nation these drastic steps need not be taken, because it has become clear to us that there is another way.

NALU SUPPORTS H.R. 5990

Principles which we believe should be included in any national health insurance program are incorporated in a bill pending before the Committee on Ways and Means that was introduced by the distinguished member of this Subcommittee, Congressman Omar Burleson. The Burleson bill, H.R. 5990, is, in our judgment, the best approach for developing an overall program which builds on the present system, strengthens what we have, adds innovations where we need them, and makes the whole system work for all the people.

Briefly, H.R. 5990 seeks to 1) increase the supply and improve the distribution of health manpower and facilities; 2) develop ambulatory care facilities which promote health through prevention and maintenance programs; 3) reiterate the need recognized in Public Law 93–641, the National Health Planning and Resources Development Act of 1974, for healthcare planning at the highest level designed to achieve a more efficient distribution of our present healthcare resources while planning improvements for the future, introduce stronger cost control mechanisms, and establish goals and priorities as part of overall healthcare planning; and 4) improve the financing mechanisms needed to carry out the Nation's healthcare policy so that everyone will be able to take advantage of needed healthcare services.

NALU believes that any program adopted by the Congress should have elements dealing with each of the above categories because in our Association's view the shortcomings cited in the healthcare system are not associated with any one single part, but rather are a collection of difficulties which taken together produce an end result that is below the level of excellence of which we as a Nation are capable. H.R. 5990 does address all these areas and makes sound proposals for improvement.

INCREASING SUPPLY OF HEALTHCARE PERSONNEL

Firstly, H.R. 5990 proposes to increase the supply of all healthcare personnel through a series of grants and loans which will enable more people to embark upon careers in the health field. These not only include doctors and nurses, but medical technicians and allied health personnel who are expected to extend the services of primary healthcare personnel. Included among categories earmarked for grants are individuals who will be trained to provide services in the ambulatory healthcare facilities also proposed by the bill.

DISTRIBUTION OF HEALTHCARE PERSONNEL

But, increasing the supply of healthcare personnel alone will not do the entire job; the personnel must be distributed where the need is, and so H.R. 5990 proposes an incentive for the personnel trained through the grant and loan programs to locate in areas of current shortage. The bill would do this by offering to forgive on a scheduled basis the loans made to the medical personnel willing to locate in an area of need. While perhaps not guaranteeing that each individual would be willing to locate in one of these areas permanently, at least continuing provisional care would be forthcoming, and the chances are that many of the individuals in the program would be interested in continuing careers in geographical areas of need.

AMBULATORY HEALTHCARE FACILITIES

H.R. 5990 encourages the creation of ambulatory healthcare centers whose primary responsibility and emphasis would be desease prevention and health maintenance and treatment of illnesses on an out patient basis. It has been well documented that hospital care is the most expensive type of care. Regrettably, hospitalization is often prescribed when treatment could just as efficiently be provided on an out patient basis, if available. Often, though, convenient out patient facilities are not available or practical. H.R. 5990 provides for loans and grants for the construction of new ambulatory healthcare centers and the modernization of those which already exist.

PLANNING

In order to coordinate all the aspects of our healthcare system, NALU believes that planning and management should be instituted at the highest levels. NALU notes with approval, therefore, the program enacted last January known as the National Health Planning and Resources Development Act of 1974. This Act, when fully implemented, promises to accomplish most of what H.R. 5990 recommends in the way of health planning, particularly in areas involving the development of a national policy on healthcare, coordination of all federal health programs, evaluation of current programs with the authority to make revisions where needed, and the coordination of programs designed to properly distribute the personnel, services and facilities which are available to deliver healthcare.

Management of the overall healthcare system is an absolute necessity if the system is ever to provide adequate basic benefits to all people at a reasonable cost. One of the most important advantages which coordinated planning is expected to provide is a method of ultimately controlling the cost of healthcare. With the cost of healthcare rising at a pace significantly higher than general inflation, it should be evident that the money we spend each year is not necessarily buying better healthcare services, and that we must find a means of leveling off costs if we are to maintain the strong foundation of the health delivery system. Until we do this, it is really too early to talk about providing new services since one of the disturbing side effects of opening the doors of healthcare to people admittedly deserving but who now have difficulty in getting in is an upward pressure on costs which redounds to the detriment of everyone using the system. At some point there has to be an individual or agency with the broadest responsibility for the administration of the healthcare system. NALU is delighted that this authority has been created and looks forward to positive results.

HEALTHCARE INSURANCE FOR ALL

The final recommendations contained in H.R. 5990 which we will cover deal with a topic of special interest to NALU. Making comprehensive healthcare insurance available to all who need it and want it is a task which is primarily the responsibility of the insurance industry and one which NALU gladly embraces.

As envisioned by H.R. 5990, a health insurance program would be created which will provide equal, adequate, basic benefits to all people whether the benefits are purchased by employer-employee groups, self employed persons, individuals, or offered to the rest of the population through plans coordinated by each state. Minimum standards would be set for each policy which would provide comprehensive coverage including coverage for catastrophic illness. H.R. 5990 envisions that such a program should be phased in over a reasonable period of time and recommends an eight year period of time designed to correspond to the development of additional professionals and facilities. When fully in place the system would emphasize prevention and maintenance while at the same time provide traditional coverage for episodic injuries and illnesses.

Public acceptance of two of the programs envisioned by H.R. 5990, the employer-employee plan and the individual healthcare plan, would be encouraged through the present tax system. NALU believes that such a system may not be appealing to some segments of the population who favor a mandatory plan. But, NALU believes that to the extent that healthcare may be deemed a right, some people may choose not to exercise that right, and they should be granted the option of not participating to the degree envisioned by the bill. But, for those who do wish to participate there is a strong incentive to do so, and at least at the basic comprehensive level called for in the bill, because tax benefits would only accrue to approved plans. NALU believes that the tax incentives in the bill are sufficient to make it attractive for most persons to acquire approved, basic coverage, and that a non-mandatory method should be tried before any other type of program is imposed.

With respect to health insurance, poor and near poor persons would be placed in a position of equality with the rest of the population if the principles of H.R. 5990 were adopted. Poor and near poor individuals would be eligible for the same comprehensive set of basic benefits as those available to employer-employee groups and individuals. People under officially designated poverty levels would pay no premiums at all, while those who could afford something would be asked to contribute on a scheduled basis in keeping with their income. Also eligible for the state healthcare plans would be workers regularly employed who have been layed off for two consecutive months. This feature would eliminate the need to consider legislation designed just for unemployed workers such as the several measures this Committee considered last Spring.

H.R. 5990 recommends that the state sanctioned plans for the poor and near poor be administered by a state approved carrier which had also been granted approval by the Secretary of Health, Education and Welfare. Rates for the state plans would be set by the carrier, the state insurance commissioner, and the chief actuary of the Social Security Administration. Costs would be absorbed by the Federal Government from general revenues on a 70 to 90 percent basis depending on the income level of the particular state.

The bill envisions that a separate state facility or pool will be created to provide the same basic, qualified health insurance to persons who have been designated uninsurable. This would guarantee that persons who presently cannot acquire health insurance will be able to enjoy the same basic standard health insurance protection available to the rest of the population. And, the risk for the people previously uninsurable for health reasons will be borne by the health insurance industry, not the taxpayer.

COSTS

If enacted before the end of the current session of Congress, it is estimated that H.R. 5990 would require the General Treasury to expend an additional $10.3 billion in its first full year of operation. While we recognize this to be a sizeable sum and particularly difficult to commit in this year of incredible budget deficits, we believe that if the country delays longer, the sums necessary to transform the total healthcare system along the lines envisioned by H.R. 5990 will only grow.

We also recognize that there are plans put forward by other groups and individuals, some which cost more in terms of new federal spending and some which cost less than H.R. 5990. In the case of the more expensive plans, they are more costly because generally they attempt to do too much and displace too much of the existing system, even portions of the system which are performing well. In the case of the proposals which cost less in terms of new federal spending, they generally do too little, although to their great credit they recognize that the present system should be preserved as much as possible. Only H.R. 5990 strikes what we think is the proper balance between cost and effectiveness so vital if we are to marital all our resources to guarantee access for all the people to quality healthcare, and it does it at a reasonable price.

Mr. Rostenkowski. Mr. Leslie Cheek.

STATEMENT OF LESLIE CHEEK III, VICE PRESIDENT, FEDERAL AFFAIRS, AMERICAN INSURANCE ASSOCIATION, ACCOMPANIED BY JAMES L. KIMBLE, ASSOCIATE COUNSEL

Mr. Cheek. Thank you.

I am Leslie Cheek, vice president, Federal affairs of the American Insurance Association. With me is James Kimble, who is associate counsel in our Washington office.

You have before you our prepared statement, which is a condensed version of our previous submissions to the full committee on this subject.

With your permission, we would like to have both our prepared statement and the statement that we submitted to the full committee in June of 1974 entered into the record.

Mr. Rostenkowski. Without objection.

Mr. Cheek. We are here today to urge that any national health insurance measure considered by this subcommittee recognize the importance of two major systems of medical, hospital and rehabilitation benefits—no-fault insurance and workers' compensation—by making the benefits under those systems primary to, that is, payable before, any benefits under national health insurance.

Making no-fault and workers' compensation benefits primary to national health insurance benefits would reduce the costs of national health insurance by $3 billion or $4 billion a year, while preserving private insurance systems funded by their beneficiaries rather than by the public at large.

Automobile accidents injure or kill 15 million people every year at a cost of $1.7 billion in medical, hospital, and rehabilitation expenses. No-fault auto insurance, which is in effect in 16 States now, and is pending in the Congress, is designed to pay, not only these costs, but also a variety of other economic losses associated with auto accidents, without regard to fault.

One of the major values of no-fault is its ability to assure the payment of the losses of all automobile accident victims from a single source, the accident victim's own insurance.

The principle involved is the internalization of the costs associated with automobile accidents to an insurance system designed for and funded by its beneficiaries, America's 126 million motorists.

We do not believe it would be sound public policy to undermine this principle by requiring the nonmotoring segment of our population to in effect subsidize their motoring counterparts by shifting the payment of $1.7 billion in motoring related costs out of the auto insurance system and into the national health insurance system.

Moreover, such a shift would involve two insurance systems rather than one in the payment of claims from 15 million motorists per year. We believe this would be a highly inefficient approach.

In the workers' compensation system, the Nation has had for more than half century a means of compensating the victims of work-related accidents and illnesses that is funded by the purchasers of the products and services sold by the employers of the system's beneficiaries.

Here again, the principle of internalization can be seen in that the insurance system that pays the more than $1 billion in annual medical costs associated with work-related accidents and illnesses is a part of the cost of producing our Nation's goods and services.

Here, too, we believe it would be unsound to hide the true costs of workplace accidents and illnesses by distributing a substantial part of them over our entire population through a national health insurance system.

Moreover, such a distribution would remove a major incentive to employers to improve workplace safety by lifting the costs of work-related medical expenses from their shoulders.

Finally, taking medical care out of the workers' compensation system would destroy the rehabilitation programs that insurers have developed to get workers back on the job. If workers' compensation carriers are no longer responsible for work-related medical costs, there will be slight incentive to encourage worker rehabilitation.

We are pleased to note that all the major proposals before this committee provide for the primary of workers' compensation benefits, and two of the proposals, H.R. 1 by Mr. Ullman and H.R. 5990 by Mr. Burleson, provide for the primacy of auto insurance benefits as well.

To summarize, we urge the subcommittee to provide for the primacy of workers' compensation and no-fault auto insurance benefits in any measure it approves. Such provisions would guarantee substantial cost savings to the national health insurance system and preserve the important values of the two major private insurance systems.

We would be pleased to answer any questions.

[The prepared statement and attachment follows:]

STATEMENT OF THE AMERICAN INSURANCE ASSOCIATION

Mr. Chairman and Members of the Committee: I am Leslie Cheek, Vice President—Federal Affairs of the American Insurance Association, whose membership of 138 insurance companies writes all lines of property and casualty insurance throughout the United States. I am accompanied by James L. Kimble, Associate Counsel in our Washington office. We appreciate the opportunity to express our association's views on certain aspects and implications of the National Health Insurance proposals currently pending before the Committee.

A substantial proportion of our membership also belongs to the Health Insurance Association of American, whose testimony the Committee will receive today. We support the recommendations of the HIAA on the substantive aspects of the pending legislative proposals.

We are here today because we are concerned about the possible impact of a national health insurance program on the workers' compensation insurance now written by our membership, and on the no-fault automobile insurance that we are confident will become compulsory in an increasing number of states in the years to come and is presently being considered by the Congress in the form of a federal minimum standards proposal.

We believe that any National Health Insurance system created by the Congress should seek to take advantage of existing insurance systems to the extent that the goals of those systems are compatible with the goals of a National Health Insurance program, and to the extent that they can assure savings to the National Health Insurance system while providing the same uniformity and universality of protection.

Two such existing systems are the workers' compensation system now in operation in every American jurisdiction, and the compulsory no-fault auto insurance system that many states already have enacted and which in this Congress may become the law of the land through federal enactment.

The purpose of this statement is to recomend that workers' compensation insurance benefits and benefits under compulsory first-party no-fault automobile insurance laws be explicitly made primary to—that is, payable before—benefits payable under a National Health Insurance program.

We believe that these private systems can achieve, in their clearly defined areas of competence, the goals of a National Health Insurance system at the same or lower cost to the consumer and with considerable savings to the federal government.

NO-FAULT AUTO INSURANCE SHOULD BE PRIMARY

(1) The Costs of Motoring Should Be Internalized to the Activity of Motoring

We think it is important for a number of reasons to internalize to motoring the cost of that activity, so that automobile accident costs will be accurately reflected in auto insurance prices.

From the point of view of auto accident victims, consumers and American society at large, it is a matter of sound economic resources allocation as well as of elementary fairness that an activity that generates costs should bear those costs.

Almost one-half of the American population does not drive automobiles. The 100 million non-motoring American people should not be forced to subsidize a portion of the $1.7 billion in medical and hospital losses generated by the motoring segment of the American public each year through higher taxes or premiums for a National Health Insurance program.

For consumers generally, automobile accident costs should be internalized to the activity of motoring in a visible way, one that shows on the price tag. The accident cost of motoring can best be internalized to the activity of motoring through the no-fault auto insurance mechanism, one that makes the cost visible before, rather than after, the consumer decides whether, when and how much to engage in the activity of motoring.

From the point of view of the auto accident victim, it is only fair that his losses be paid for by the motoring populace through their common contributions to the no-fault auto insurance pool, rather than by society at large through its contribution to a national health insurance system.

The price of automobile insurance is an integral part of the total cost of owning and operating an automobile. There should be no disparities in automobile insurance costs that are not justified by real differences in auto accident loss exposure.

WORKERS' COMPENSATION BENEFITS SHOULD BE PRIMARY

For most American workers the greatest fear is the possibility of having to leave their employment because of an occupational disability. Even relatively nonserious injuries or illnesses may result in medical care expense while the more serious disabilities may cause a temporary or permanent loss of earning ability along with the burden of catastrophic medical expenses. Likewise, liability for such losses is an equally real threat to employers. Fortunately, this nation recognized the serious implications posed by occupational hazards at an early point and devised a system—Workers' Compensation—to meet the needs of both employees and employers for protection from occupational disabilities.

For more than a half-century, workers' compensation has served this nation well by providing to injured employees, or to the dependents of those killed in industry, effective medical care and other benefits—regardless of the blame for the accidents.

It is essential that medical care for working injuries be retained as part of the workers' compensation system. Duplication or pre-emption of such care through another system would not only be economically unsound but would have a disastrous effect on the satisfactory operation of workers' compensation. It could easily result in its destruction.

Medical reports on initial treatment, periodic progress and termination of treatment are absolutely necessary to the operation of the workers' compensation system. These reports would be difficult if not impossible to obtain if medical treatment were provided through another system. At best, serious delays would occur.

Removal of the medical component of the workers' compensation benefit package would eliminate the incentive to employers to provide comprehensive safety programs in order to reduce work related accidents. Additionally, the casualty insurance industry's commitment to physical and vocational rehabilitation and the expertise in the management of traumatic injuries can not be maintained if the workers' compensation system is no longer responsible for medical treatment.

Existing federal law wisely recognizes the importance of retaining medical care for work injuries as part of the workers' compensation system. When Medicare was first provided in 1965, duplication of workmen's compensation medical benefits was avoided. Section 1862(b), Title XVII (Medicare) of the Social Security Act provides that:

"Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under workmen's compensation law or plan of the United States or a State."

This subsection also provides for reimbursement to the appropriate Trust Fund in the event payment is made for an item or service covered by such law or plan.

In 1967, Paragraph 25 was added to Section 1902(a), Title XIX (Medicaid) of the Social Security Act, which lists conditions which a state plan must meet to receive federal medical assistance. In effect, that paragraph provides that the state, in administering plans for medical assistance, must take all reasonable measures to ascertain the legal liability of third parties (including obviously that under the workmen's compensation laws) to pay for care and services arising out of injury, disease, or disability. Such legal liability is to be treated as a resource of the individual on whose behalf the care and services are made available. Provision here again is also made for reimbursement in the event care is provided under the plan.

Medical protection under workmen's compensation laws provides the most comprehensive system of statutory health care in this country. Full medical, hospital and related services, unlimited in time or amount, are required in 46 states. Coverage for all occupational disease is now mandated in all but five states. Rehabilitation of disabled workers is now provided in 41 states. Severe injuries involving large expenditures for medical care, while fortunately infrequent, are by no means unknown. Current medical payments under workmen's compensation laws exceed $1,000,000,000 annually.

For the reasons above, we strongly urge the Committee to include in its National Health Insurance legislation language making workers' compensation benefits primary to National Health Insurance benefits and making mandatory first-party automobile accident insurance by the primary source of indemnity for auto accident injuries.

STATEMENT OF AMERICAN INSURANCE ASSOCIATION ON NATIONAL HEALTH INSURANCE, SUBMITTED TO THE COMMITTEE ON FINANCE, U.S. SENATE, JUNE 5, 1974

Mr. Chairman and Members of the Committee: The American Insurance Association, whose membership of 127 insurance companies writes all lines of property and casualty insurance throughout the United States, appreciates the opportunity to express its views on certain aspects and implications of the National Health Insurance proposals currently pending before the Committee.

A substantial proportion of our membership also belongs to the Health Insurance Association of America, whose testimony the Committee has already received. We support the recommendations of the HIAA on the substantive aspects of the pending legislative proposals.

We are submitting this statement because we are concerned about the possible impact of a national health insurance program on the workmen's compensation insurance now written by our membership, and on the no-fault automobile insurance that we are confident will become compulsory in an increasing number of states in the years to come.

The membership of the American Insurance Association includes many of the major writers of group health insurance; automobile bodily injury liability and medical payments insurance; workmen's compensation; and individual accident and health insurance. In addition, at least one of our member companies has served as an administrative agency for the Medicare program. Accordingly, we believe our views come from balanced, first-hand knowledge of and experience with almost all of the benefit systems we will be discussing.

INTRODUCTION

We believe that any National Health Insurance system created by the Congress should seek to take advantage of existing insurance systems to the extent that the goals of those systems are compatible with the goals of a National Health Insurance program, and to the extent that they can assure savings to the National Health Insurance system while providing the same uniformity and universality of protection.

Two such existing systems are the workmen's compensation system now in operation in every American jurisdiction, and the compulsory no-fault auto insurance system that many states already have enacted and which in this season of Congress may become the law of the land through federal enactment.

The purpose of this statement is to recommend that workmen's compensation insurance benefits and benefits under compulsory first-party no-fault automobile insurance laws be explicitly made primary to—that is, payable before—benefits payable under a National Health Insurance program.

We believe that these private systems can achieve, in their clearly defined areas of competence, the loans of a National Health Insurance system at the same or lower cost to the consumer and with considerable savings to the federal government.

Moreover, the preservation of existing private systems for the compensation of work—and auto accident-related injuries will serve several major public policy objectives.

The goals of a National Health Insurance program and of the Workmen's compensation and no-fault automobile insurance systems are the same: (1) the provision of adequate economic loss benefits for all at minimum cost; and (2) the restructuring of the framework under which these benefits are delivered in order to reduce frictional costs, eliminate waste and duplication, redirect resources to reduce the frequency and severity of losses, and encourage rehabilitation.

As we shall demonstrate below, the objectives of all three systems will be enhanced if benefits under no-fault automobile insurance and workmen's compensation are made primary to benefits under a national health insurance system.

NO-FAULT AUTO INSURANCE SHOULD BE PRIMARY

(1) *The Costs of Motoring Should Be Internalized to the Activity of Motoring*

We think it is important for a number of reasons to internalize to motoring the cost of that activity, so that automobile accident costs will be accurately reflected in auto insurance prices.

From the point of view of auto accident victims, consumers and American society at large, it is a matter of sound economic resources allocation as well as of elementary fairness that an activity that generates costs should bear those costs.

Almost one-half of the American population does not drive automobiles. The 100 million non-motoring American people should not be forced to subsidize a portion of the losses generated by the motoring segment of the American public through higher taxes or premiums for a National Health Insurance program.

For consumers generally, automobile accident costs should be internalized to the activity of motoring in a visible way, one that shows on the price tag. The accident cost of motoring can best be internalized to the activity of motoring through the no-fault auto insurance mechanism, one that makes the cost visible before, rather than after, the consumer decides whether, when and how much to engage in the activity of motoring.

From the point of view of the accident victim, it is only fair that his losses be paid for by the motoring populace through their common contributions to the no-fault auto insurance pool. rather than by society at large through its contribution to a national health insurance system.

The price of automobile insurance is an integral part of the total cost of owning and operating an automobile. There should be no disparities in automobile insurance costs that are not justified by real differences in auto accident loss exposure.

The statistical separation of auto accident losses from other kinds of losses, which a primary no-fault automobile insurance system would assure, would demonstrate the cost of automobile transportation relative to the costs of alternative modes of transportation, for example. The public interest in the rational allocation of transportation resources would be ill-served if a portion of the true cost of motoring were hidden from scrutiny, as it would be if the auto insurance system were secondary.

(2) *Motoring Accident Losses Merit Separate Treatment*

Four out of every five American families own a car. More than 118 million licensed drivers use more than 100 million cars on our streets and highways. There is a 99 percent chance that in 20 years of driving, every one of these drivers will have at least one accident. Each year, motoring activity results in 56,000 deaths and 4.6 million injuries (of which half are serious and 4 percent result in permanent disability). The economic loss to the nation from the carnage on our highways amounts to $19.4 billion per year.

Moreover, 7.7 percent of all disabilities are attributable to automobile accidents; 21.5 percent of the overall number of days of disabilities from accidents are attributable to auto crashes; and 49 percent of all accidental deaths in America each year are attributable to auto accidents.

Although auto accident-related medical expenses constitute less than 5 percent of the total annual medical expense outlay in the United States, the types of injuries and disabilities are significantly different from non-auto related injuries to justify their treatment and compensation under a system directed exclusively to them.

If auto insurance is primary, insurers will be able to bring to bear on automobile accident injuries the expertise they have developed through the rehabilitation of trauma cases under the workmen's compensation system. The effect of this expertise would be greatly diluted if auto accident injuries were compensated by a National Health Insurance system whose benefits are primary to those under no-fault automobile insurance.

In addition, as has been the case in workmen's compensation, the insurance industry's private enterprise motive for reducing costs would encourage prompt emergency treatment and rehabilitation of automobile accident victims.

Finally, isolating the medical costs of automobile accidents within the no-fault automobile insurance framework will facilitate the generation of sufficient statistical evidence regarding the nature and causes of automobile injuries to maximize systematic approaches to automobile and highway traffic safety. This effort, too, would be substantially diluted if part of the cost of auto accident injuries were absorbed by a system separate from the no-fault auto insurance system.

(3) *No-Fault Auto Insurance Eliminates the Need for Collateral Sources*

Because the current automobile liability insurance policy is designed not to compensate the policyholder for his accident losses, but to protect him from the economic consequences of judgments against him, prudent drivers today must rely on other forms of insurance to pay their hospital and medical expenses resulting from automobile accidents in which they are either "at fault" or precluded from recovering from other parties by their "contributory negligence".

The elimination of questions of legal fault from auto accident reparations and the adoption of a compulsory first-party auto insurance system will reverse the current situation. Each driver will be able to look to his own insurer for full and immediate payment of all hospital and medical expenses and other economic losses incurred by those injured in his automobile.[1]

(4) *National Health Insurance Would Not Be More Efficient Than Private No-Fault Auto Insurance*

It is fallacious to assume that the ratio of expenses to losses in the operation of an insurance system provides an index to the efficiency of that system. The more complex the economic benefit afforded by the insurance, the more expensive the claim service will be. However, the fact that it is more expensive is no indication whatsoever that it is less efficient.

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[1] For a description of how such a system would operate see the "Report of the Special Committee to Study and Evaluate the Keeton-O'Connell Protection Plan and Automobile Accident Reparations," American Insurance Association, New York, 1968, p. 5–7; and "Motor Vehicle Crash Losses and Their Compensation in the United States," U.S. Dept. of Transportation, March, 1971, pp. 133–37.

No-fault auto insurance encompasses not only unlimited hospital, medical and rehabilitation benefits, but also wage loss benefits of up to $1,000 a month, replacement household service benefits for injured housewives, and compensation for damage to vehicular and non-vehicular property. With this broad range of claim services to perform, the insurer's expenses naturally are higher than in lines of insurance offering less comprehensive benefits.

Shifting the administrative costs of processing automobile bodily injury claims to a National Health Insurance system would not greatly reduce the administrative burden of the no-fault automobile insurer, since any accident causing significant injury would undoubtedly be accompanied by a considerable degree of property damage. Thus, the automobile insurer would be in the act anyway, and the additional cost of processing the injury portion of the claim would be negligible. The shift of the administrative cost to the National Health Insurance system would result in the creation of unused capacity in the private no-fault auto insurance system, while imposing on the national health insurance system the cost of processing some 4.6 million auto bodily injury claims each year. We do not believe it would be sound to under-utilize an established system in this manner while adding unnecessary costs to a new system.

We firmly believe that coordination of benefits among alternative sources should be explicitly dealt with by the National Health Insurance legislation. We would suggest that the most efficient coordination of benefits in the auto accident compensation area would be one which makes the more comprehensive of two mandatory systems, that is, the no-fault system, primary to the less comprehensive system, that is, National Health Insurance.

WORKMEN'S COMPENSATION BENEFITS SHOULD BE PRIMARY

(1) *The Workmen's Compensation System Serves American Workers and Employers Well*

For most American workers the greatest fear is the possibility of having to leave their employment because of an occupational disability. Even relatively non-serious injuries or illnesses may result in medical care expense while the more serious disabilities may cause a temporary or permanent loss of earning ability along with the burden of catastrophic medical expenses. Likewise, liability for such losses is an equally real threat to employers. Fortunately, this nation recognized the serious implications posed by occupational hazards at an early point and devised a system—Workmen's Compensation—to meet the needs of both employees and employers for protection from ocupational disabilities.

For more than a half-century, workmen's compensation has served this nation well by providing to injured employees, or to the dependents of those killed in industry, effective medical care and other benefits—regardless of blame for the accidents.

(2) *The Importance of Medical Care to Workmen's Compensation*

It is essential that medical care for work injuries be retained as part of the workmen's compensation system. Duplication or pre-emption of such care through another system would not only be economically unsound but would have a disastrous effect on the satisfactory operation of workmen's compensation. It could easily result in its destruction.

Medical reports on initial treatment, periodic progress and termination of treatment are absolutely necessary to the operation of the workmen's compensation system. These reports would be difficult if not impossible to obtain if medical treatment were provided through another system. At best, serious delays would occur.

Existing federal law wisely recognizes the importance of retaining medical care for work injuries as part of the workmen's compensation system. When Medicare was first provided in 1965, duplication of workmen's compensation medical benefits was avoided. Section 1862(b), Title XVII (Medicare) of the Social Security Act provides that:

"Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State."

This subsection also provides for reimbursement to the appropriate Trust Fund in the event payment is made for an item or service covered by such law or plan.

In 1967, Paragraph 25 was added to Section 1902(a), Title XIX (Medicaid) of the Social Security Act, which lists conditions which a state plan must meet to receive federal medical assistance. In effect, that paragraph provides that the state, in administering plans for medical assistance, must take all reasonable measures to ascertain the legal liability of third parties (including obviously that under the workmen's compensation laws) to pay for care and services arising out of injury, disease, or disability. Such legal liability is to be treated as a resource of the individual on whose behalf the care and services are made available. Provision here again is also made for reimbursement in the event care is provided under the plan.

(3) *Workmen's Compensation Provides Comprehensive Protection*

It should be noted that under neither the Medicare program nor the Medicaid program do the extent of medical care benefits approach those provided under the workmen's compensation system. Medical protection under workmen's compensation laws provides the most comprehensive system of statutory health care in this country. Full medical, hospital and related services, unlimited in time or amount, are required in 48 jurisdictions. Severe injuries involving large expenditures for medical care, while fortunately infrequent, are by no means unknown. Current medical payments under workmen's compensation laws exceed $1,000,000,000 annually.

CONCLUSION

For the reasons above, we strongly urge the Committee to include in its National Health Insurance legislation language making workmen's compensation benefits primary to National Health Insurance benefits and embodying the concept that mandatory first-party automobile accident insurance be the primary source of indemnity for auto accident injuries.

We also urge the Committee to specify that with the exception of Social Security and workmen's compensation, all other benefits, including National Health Insurance and statutory disability protection, be eliminated as to auto accident-incurred injury or disability or made excess of mandatory first-party no-fault automobile insurance.

The Health Insurance Association of America supports our view that workmen's compensation and non-occupational hospital, medical and surgical benefits under mandatory national or state no-fault automobile insurance laws should be primary to National Health Insurance benefits.

We would be happy to meet with members of the Committee or the Committee Staff to discuss in further detail the recommendations contained in this statement.

Mr. ROSTENKOWSKI. Thank you, Mr. Cheek.

Are there any questions of the witness?

Mr. DUNCAN. I have one, Mr. Chairman.

In the absence of national no-fault insurance, would it be appropriate to use NHI to take care of all medical costs just in the States that have no-fault insurance?

Mr. CHEEK. The problem that you would have in a patchwork no-fault system without national uniformity of medical benefits is that it would be difficult to equitably apportion the costs of national health insurance among the States. This is a difficulty that we have a very hard time dealing with.

Mr. DUNCAN. What has been your experience in the States that have the no-fault automobile insurance now?

Mr. CHEEK. It has been very favorable, both in terms of the service that we are able to give our policyholders, and in terms of what the policyholders get when they are hurt.

Mr. DUNCAN. But haven't the rates increased in most of those States?

Mr. CHEEK. No, sir.

Mr. DUNCAN. I read last week that the automobile insurance rates had increased in Massachusetts and Florida.

Mr. CHEEK. Auto insurance rates are going up everywhere in the Union. What we found in the early years of no-fault was that costs went down. These were years—1971, 1972, and 1973—in which costs were reasonably stable. And we were in fact able to reduce premiums substantially, particularly in Massachusetts. And in 11 of the 16 States that have enacted no-fault, premium reductions were mandated as part of the statute that implemented the system.

What we have found since January of 1974, particularly, is that inflation in the things that we pay for, chiefly medical and hospital costs and crash-repair parts, has outstripped inflation in most other areas of the economy.

Also, in 1974 the stock market virtually collapsed, wiping out a substantial proportion of our companies' surplus, which made great increases in both fault and no-fault States inevitable.

But generally speaking, Mr. Duncan, the costs of a no-fault system are less than those of a fault system.

Mr. DUNCAN. The articles I read a week or 10 days ago on the Florida experience was that the insurance rates in the past year had increased at a greater rate than in most States that do not have the no-fault insurance.

Mr. CHEEK. That is true as far as Dade County is concerned. The Florida no-fault law has what is called a medical expense threshold of $1,000. If your medical expenses fall below that threshold, you cannot sue for what is called pain and suffering, but if they exceed it you can.

We have found, and a grand jury is investigating what we have found, that lawyers and doctors and claimants in that area of Florida have in effect colluded in an effort to bring the claimants over that threshold. Thus it is true in the Dade County area, auto insurance costs have been rising quite a bit faster than in other parts of the State, and in other no-fault States.

Mr. DUNCAN. I think it is true that where people might have saved some money by no-fault, that automobile insurance underwriters are also taking advantage of that fact and increasing their costs.

Is that true, also?

Mr. CHEEK. No, sir. The greatest proportion of the increases in costs have occurred in the physical damage portions of the premium, not the bodily injury portion.

Mr. DUNCAN. Thank you, sir.

My time is up. I would like to discuss it further with you. Thank you for a good presentation. It has been helpful.

Mr. CHEEK. Thank you.

Mr. ROSTENKOWSKI. Thank you, Mr. Cheek.

Mr. John O'Day.

STATEMENT OF JOHN B. O'DAY, PRESIDENT-MANAGING DIRECTOR, INSURANCE ECONOMICS SOCIETY OF AMERICA

Mr. O'DAY. Mr. Chairman, my name is John B. O'Day, and I am president-managing director of the Insurance Economics Society of America. The society, founded in 1917, is an organization engaged in the continuous study of social and private insurance systems in the United States. Members of the society consist of a select group of insurance companies who are among the pioneers in the development of America's unique and unprecedented health insurance system, and 6,000 insurance agents who are engaged in marketing and servicing health insurance.

We appear before you today for two reasons:

To support the principles embodied in the National Health Care Act of 1975, H.R. 5990, sponsored by Congressman Omar Burleson. This is our third statement on the Burleson bill since this particular sequence of congressional hearings began in November 1971; and to register the society's unalterable opposition to a Government takeover of the private health-care system and the private health insurance system in the United States.

Such a takeover has been proposed to your committee to be implemented through an expansion of the Social Security Act and to be funded by sizable increases in the American worker's social security tax. This second reason precedes today's hearings by over three decades, for it was in 1943 that the society first testified before Congress on the very subject of today's hearings, government health insurance.

SUPPORT OF H.R. 5990

In the interest of time we will not repeat in detail, though we do affirm, our arguments in favor of the National Health Care Act which have been recorded on pages 3184 through 3190 in the published transcript of the committee's October–November 1971 hearings.

We said then and we say now that "Today's Americans are as much in need of freedom in how each shall minister unto his own body as those who sailed into the bays of Massachusetts and Chesapeake, and those who walked to the Great Salt Lake were in need of freedom to minister each unto his own soul."

State medicine, we have ample evidence from abroad, is as self-defeating as State religion. It should be scorned.

We said then and we say now that H.R. 5990 acknowledges the unique voluntary American system of private health insurance that no other country in the world has even been given the opportunity to enjoy. There are deficiencies, yes. And it is the underlying genius of Congressman Burleson's bill that singles out these deficiencies and seeks to redress each of them without destroying the whole of the American health-care system.

LAWS OF ECONOMICS

It has been said that no matter what national health insurance program is adopted by Congress, medical costs are sure to go up because of the economic law—the cost of illness increases with the ability to collect for it.

Perhaps this law can be borne out by the recent newspaper survey (below) of the daily rate of a semiprivate room in 28 Chicago area hospitals. The range is from $70 to $144 with the exception of Cook County Hospital at $209.

The $209 rate covers "everything" a hospital spokesman reportedly said—"Hospital room, surgeons, drugs, tests, therapy, et cetera." Cook County Hospital bills are largely paid out of public funds.

The list that follows shows the daily charges in the other hospitals throughout Chicagoland in that particular survey.

[The table follows:]

DAILY CHARGES COVER WIDE RANGE IN CHICAGO

Hospital	Private room	Semiprivate
University of Illinois	$121	$121.00
Michael Reese	162	144.00
Ingalls	85	80.00
Northlake Community	103	98.50
Ravenswood	114	102.00
Oak Park	93	86.00
Cook County	209	209.00
St. Francis Hospital	92–99	81–90.00
St. Anne's	97–99	91–93.00
Northwestern Memorial	107–112	102–104.00
Rush Presbyterian St. Lukes	142–145	137.00
Westlake Community	72	70.00
Holy Family	94	89.00
Jackson Park	140	110.00
Skokie Valley Community	100	94.00
Mercy	127–130	126.00
Lutheran General	None	118.00
Henrotin	88–97	85.00
Mount Sinai	125	120.00
Northwest Community	None	72.50
Little Company of Mary	92	83.00
Woodlawn	114	107.00
Evanston	135	116.00
Billings (University of Chicago)	148	143.00
Palos Community	100	90.00
St. Joseph	107	102.00
Memorial Hospital of DuPage County	87	81.00
Edgewater	90–140	82.00

CEILINGS ON FAMILY EXPENDITURES

Mr. O'Day. H.R. 5990 would place a limit of $1,000 on the amount a family would pay in deductibles and copayments in any benefit year for catastrophic illnesses. This would add just one of the controls on raising costs that are contained in H.R. 5990 to offset the aforementioned economic law.

Yet there would be no dollar limit on total benefits. The poor, near poor, and unemployed would be covered with scaled down copayments according to income, if any.

SOCIAL SECURITY TAX BURDEN

The society has testified previously on the accelerating growth of social security taxes. In our testimony before this committee on May 23, 1974, we charted the increase in the combined social security tax rate from 2 percent to 11.7 percent in 25 years.

We also charted the increasing tax base from $3,000 to $13,200 from 1949 through 1974. Since then the social security tax base was increased in 1975 to $14,100 and in a few weeks it will be increased automatically to $15,300 for 1976.

The maximum combined tax will have increased from $1,544.40 per year per worker for 1974, to $1,790.10 for 1976. This amounts to a $245.70 increase, 16 percent since we testified on this point less than 18 months ago.

Despite these very sharp increases in the social security tax, ironically they are not expected to offset the projected deficits of $3 billion this year and $6 billion next year, the first unanticipated drains on the social security trust funds.

We repeat our plea to Congress. Do not place another burden on the social security tax structure, which is currently being strained from all quarters, by seriously considering any national health insurance program which would be funded by social security taxes.

In conclusion, may we respectfully suggest to this committee to consider H.R. 5990 as one that:

One, would not take more money out of the American pocket for a new social security health insurance program.

Two, would not take more capital from American industry; capital that is needed to create more jobs which the country needs.

Three, would not put a half-a-million people who are engaged in the private health insurance industry out of work.

Further, Mr. Chairman, for over three decades congressional committees have been told time and again that American health care is inferior and needs to be replaced by a monolithic government program.

Congress and the public have been inundated with international statistics with the conclusion that the United States is down the list of the world's nations ranked by such indicators as infant mortality and life expectancy.

The society believes that Congress has recognized that these conclusions, while they sound sensational from the platform, TV, or printed page, are founded on what journalist Harry Schwartz of the New York Times has aptly termed "simple naivete in statistical matters."

A comparison which is almost completely overlooked is the relative smallness of these countries said to be "healthier nations" when compared to the United States. Sweden, for example, is often cited as a model for the United States to follow.

Apparently many fail to realize that if we were to superimpose the whole country of Sweden on the United States we would use up scarcely more territory than Arkansas, Louisiana, and Missouri. In fact the whole Swedish population of 8 million is equivalent to those who live in New York City.

The Netherlands could fit into half of Indiana and Great Britain into Oregon. Only Oregon and Nevada would be needed to contain the largest country in Western Europe, France.

We offer the territorial comparisons, Mr. Chairman, to demonstrate that the problem of providing health care to the fourth largest country in the world with a heterogenous people numbering over 215 million, spread over a vast territory, is of such greater magnitude as to be incomparable to the relatively small countries of Europe.

Mr. Chairman, the Insurance Economics Society of America endorses the principles of the Burleson bill because it is noncompulsory while providing substantial incentives to participate. It will improve the health-care delivery system for all without restricting a person to only one form of medical care. The Burleson bill would concentrate most of the new energies and taxes to be expended on those with specific problems which have now been identified as needing the attention of Congress.

This concludes my statement, Mr. Chairman, and thank you for permitting us to be heard.

Mr. ROSTENKOWSKI. Thank you, Mr. O'Day.

This will conclude today's hearings, and we will stand adjourned until Monday morning, November 10, at 10 a.m.

[Whereupon, at 12 noon, the committee adjourned, to reconvene at 10 a.m., Monday, November 10, 1975.]

NATIONAL HEALTH INSURANCE

MONDAY, NOVEMBER 10, 1975

U.S. House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in the committee hearing room, Longworth Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. The committee will come to order.

We welcome you this morning. It is a pleasure to see you here even in this inclement weather.

Mr. McMahon, if you will identify yourself, your association and the gentleman with whom you are associated, you may proceed to your testimony.

STATEMENT OF JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT

Mr. McMahon. Thank you, Mr. Chairman.

I am John Alexander McMahon, president of the American Hospital Association. With me is Leo J. Gehrig, M.D., senior vice president of the association, who is in charge of our Washington office.

The association's membership, which consists of some 7,000 member institutions including most of the hospitals of the country, extended long-term care institutions, mental health facilities, and hospital schools of nursing, is deeply committed to providing high quality health care to all people at a reasonable cost. We welcome this opportunity to testify before your Committee on National Health Insurance and to express our views on the crucial issues of organizing, delivering, and financing the delivery of health care services to meet the Nation's health care needs.

The American Hospital Association has developed a broad framework for a system of organizing, delivery, financing, and regulating health services that is embodied in the association's policy statement on provision of health services—1971—a copy of which is included with our testimony and I would request that our full statement which I shall summarize, be entered in the record.

Mr. Rostenkowski. Without objection, that will be included in the record.

Mr. McMahon. This statement is the product of efforts that began some 6 years ago with a detailed study and review of the Nation's health care system by a special committee named by the association's board of trustees to determine how the system might be made more effective and more comprehensive, and provide better health services for all people.

On pages 2 to 4 of the full statement, Mr. Chairman, we have addressed ourselves to some goals and issues of a national health insurance plan. Before enumerating specific goals, let me say that the association in forming its recommendations sought to address the problems facing the health care system.

The first problem is the uneven access to health care services that exists; second is rising health care costs and the third is regulatory fragmentation. While much has been accomplished by the health care system in recent years in striving to overcome these problems, and while the system has made a commendable response to the demands placed on its resources by the medicare and medicaid programs, we all know that the problems have not been solved. All these persistent health care problems must be carefully addressed in the development of a national health insurance program.

Identification of the specific goals to be achieved by a national health insurance program is essential to set a basis for evaluating the specific proposals found in various bills. A program should: (1) Provide universality of coverage for all Americans through comprehensive health benefits, including inpatient and outpatient services and coverage for catastrophic illnesses; (2) Provide for equitable and adequate financing for multiple sources of funds; (3) Provide for integration and coordination of all key elements of the health care system, including the means for delivering health services, the mechanisms for financing and payment for services, and the regulatory and administrative structures; (4) Provide for preservation and encouragement of philanthropic giving for health care facilities and services; (5) Provide for a better organized, more productive health care delivery system to assure that care is available, accessible and acceptable to both consumers and providers; and (6) Provide appropriate means to insure the rendering of high-quality health care in the most economical manner.

H.R. 1, the National Health Care Services Reorganization and Financing Act, introduced by Chairman Al Ullman of the House Committee on Ways and Means, incorporates provisions which appropriately address the key issues the American Hospital Association believes must be dealt with in any national health insurance program, and, of course, we strongly support this bill.

If I may, Mr. Chairman, I would like to address myself to coverage and basic benefits summarizing material on pages 4 to 6 of our testimony. One of the most important objectives of a national health insurance program is to make a high level of comprehensive health care benefits available to all persons—the employed and the unemployed; the aged and the young; the disabled and the well; and persons of all income levels, including the poor and the near-poor. With national health insurance we can and should close the gaps in the current health insurance system through provisions for those who become unemployed, and through special means for coverage for the self-employed, small groups, and "uninsurable" segments of the population.

The benefits package of any national health insurance program should be comprehensive and include such components as are needed to maintain personal good health and to prevent illness; provide primary, specialty, restorative and health-related custodial care; cover all illnesses including catastrophic; and make available health services in both ambulatory and institutional settings depending on the needs of the patient.

The imposition of a substantial cost-sharing requirement through deductibles and high copayments in the benefits package recommended in some national health insurance bills concerns us in two ways.

First: There is too high an administrative cost in implementing a deductibles program. The cost of administering such a deductibles provision will be found to be substantial as compared to the dollars saved through the use of deductibles.

Second: A high level of deductibles and copayments could become a barrier to individuals seeking or receiving needed health care services. The out-of-pocket expenditures required to meet the deductibles could well discourage some individuals from obtaining needed care, as could the relatively high copayment provisions in some proposals. We do not believe that deductibles or high copayments are the most effective means for controlling overuse of medical services since much of medical care use is not determined by the patient, but we believe that some cost sharing is both appropriate and desirable. The best approach to achieving equitable cost sharing would be through modest copayments, rather than deductibles, and properly constructed utilization reviews are the appropriate means for preventing overuse.

We strongly support the "health card" approach that is included in H.R. 1 and a number of other NHI proposals as an important mechanism for reducing barriers to care and for increasing the administrative efficiency in the overall payment system.

Now, I would like to address catastrophic benefits coverage that appears on pages 6 to 8 of our written testimony. We believe that any national health insurance program should provide coverage for the expenses of catastrophic illnesses. However, we firmly believe that catastrophic coverage must be made a part of a comprehensive benefits package that would be made available to all persons, rather than be a separately financed and administered benefit because:

At the present time, 80 percent of the people in this country have insurance coverage for hospitals services. A separate catastrophic coverage program could duplicate much of this coverage.

The catastrophic coverage programs that have been proposed do not incorporate support for improvements in the health care delivery system that are needed if any national health insurance is to be successful.

Finally, the separation of catastrophic coverage from the basic benefits coverage would create additional administrative expense in the health insurance system. There would be duplicative recordkeeping and claims processing requirements if a substantial portion of the population had basic coverage underwritten by private insurance carriers through employer-employee groups and catastrophic coverage under a government program.

When a national health insurance program providing comprehensive benefits to all is enacted. there is certain to be an increased demand on health care facilities and services. To meet this added demand, the health care delivery system will need a greater capability, especially for providing outpatient or ambulatory care services. Authorized benefits must be matched with available and accessible services. A program should not be enacted that promises more than it can deliver. Some of the added services can be provided by using our resources more effectively rather than through an expansion of resources. To this end, support will be required for the development of more effective forms of health care delivery and to encourage the growth of existing effective delivery organizations.

It is essential that national health insurance legislation include provision for health resources development in such areas as health systems, manpower, facilities, communications, and transportation. Further, such provision should be coordinated with other programs to assist in the development of health resources. H.R. 1 seeks to do this and calls for a special study for the development of a program to provide other funds for resources to meet high-priority health service needs in underserved rural or urban areas.

Let me address myself to problems in the health delivery system as we see them today as set forth in our statement at pages 9 through 11.

To meet health care needs, existing institutional and professional providers of health care services will need to improve greatly the coordination of and access to comprehensive health care services. We believe that the AHA in its policy statement has developed an innovative approach to resolving these issues through the health care corporation (HCC) concept. This concept is incorporated in H.R. 1.

Health care corporations would be community-based, not-for-profit, private or governmental organizations that would synthesize local health resources for the delivery of comprehensive health services to defined population groups to better meet the health care needs of the community. These HCC's would serve specified geographic areas and provide comprehensive health services through their own facilities and/or through affiliations with other providers, not-for-profit and for profit.

Every HCC would have to make available high-quality comprehensive health services to all persons residing in its service area who wish to be HCC registrants.

HCC's could span political boundaries where necessary to assure that all persons have access to care. They would extend services into underserved areas, both rural and urban, thus providing an important link to a comprehensive health care system for individuals residing in these areas and also for health care professionals presently isolated from the mainstream of the system. The goal of the HCC concept as contained in H.R. 1 is to bring about the establishment of HCC's in all areas of the country. This would provide the public an opportunity to choose between the services of these comprehensive health delivery organizations and the traditional patterns of care. In many areas there would be the further possibility of selection among several HCC's.

This concept offers an opportunity to take significant steps toward solving two major problems of the health care delivery system—the need for assured access to a comprehensive level of health care for all persons, and the need for greater coordination of services.

Access to care may become a more critical problem when benefits are extended by national health insurance to the entire population. We believe that geographic responsibility of the HCC is a realistic approach with substantial promise for assuring that services would be available to all.

HCC's, like health maintenance organizations, would be responsible for providing a comprehensive range of services for all of its registrants, so that from the consumer's viewpoint, a single, identifiable and accountable organization would be responsible for meeting all of his health care needs. Thus, an important element for coordinating for the patient appropriate modalities of care, including both physician and institutional services, would be established.

Moreover, coordination and planning of services on a local, State, and national basis, can be improved through implementation of this concept. The HCC approach through its responsibility for a specified geographic area would result in nationwide system for the delivery of comprehensive services, a matter the HMO concept does not address.

Now, I would like to address financing of health care services which we have addressed beginning at page 11 in our statement.

We believe that all persons should be assured of financial access to health care and that no person should be denied health care because of inability to pay. We also believe that there should be adherence to the principle that every person who is able to do so should contribute to the cost of this health care.

To achieve the dual objective of equity in the distribution of the financial burden and effectiveness in the raising of funds, multiple sources of funds should be utilized to finance a national health insurance program, including general Federal tax revenues, Federal taxes collected through the social security mechanism, premium payments by employers and employees, and individual out-of-pocket expenditures.

Some national health insurance proposals would rely primarily on a single financing mechanism—a new Federal trust fund supported by payroll taxes and general tax revenues. Other bills would utilize the existing medicare trust fund and expand on its base. We have several concerns with the reliance on a trust fund approach in whatever form:

One. It would create inflexibility in the development and underwriting of health insurance benefits by sharply reducing the savings that accrue from competition by carriers for employer group health insurance business, and it would restrict the opportunities for savings which are possible in the tailoring of a health insurance package to the specific needs of a particular group.

Two. The manpower, facilities, and equipment that would be required to administer a national health insurance program through one governmental agency for over 200 million persons staggers the imagination.

There is no conclusive evidence to suggest that the Federal Government can do a more efficient job than private carriers in administering a broad scale program. In fact, in a study ordered by this House Ways and Means Committee, the General Accounting Office has found it costs the Government more than private insurance carriers to process each medicare claim. To dismantle a substantial portion of the existing machinery in the private market to no productive purpose makes no sense to us.

Three. The trust fund approach would require the assessment of the needs of the group served, a difficult, if not impossible, task when that group consists of more than 200 million people. Subsequent to need assessment, moreover, would be the problem of establishment of a tax rate and tax base to generate the required level of revenue to meet this need. The "pegging" involved would be extremely complex, but even more complicating would be the consequence of underestimating the needs, for if the number of dollars required to actually meet the health care needs for the Nation turn out to be greater than the amount projected and made available, the trust fund would become the indirect or even the direct rationer of health care. Certain individuals would then be forced to forgo needed health services and health care providers would be forced to cut back services, or operate at a deficit, or both.

A trust fund subject to underfinancing would channel revenue on the basis of presumptive priorities: (1) For example, an abnormal share of payments would have to be channeled to certain services, or classes of providers, or classes of patients. This channeling would be done on the basis of priorities decided by the fund's administrators, whether or not those priorities coincide with the widely varying needs of beneficaries in all parts of the country. If the bureaucratically established priorities were askew, the basic underfinancing problem would be further aggrevated by the misallocation of scarce funds. (2) A trust fund, falling short of participants' needs, would create a gap between reimbursed benefits and the actual financial requirements for providing the needed services, and place the provider in an untenable position. On the one hand, payments from the trust fund would fall short of the cost of service, and on the other, the consumer could not be billed for the difference. A deficit problem would be created for providers that could only lead to a general reduction in service or to bankruptcy.

Four. Another consequence of the trust fund system would be the inequity created through imposing taxes for health insurance on individuals and on employers that bear no relation to the number of beneficiaries covered, or to the actual utilization of services by the worker or his family. Under the typical trust fund proposal, a wage earner who is single would pay the same amounts as a married co-worker with identical earnings and a large family, and the taxes paid would bear little direct relationship to the insurance value received.

Five. Some have argued that the trust fund approach would remove a disincentive for employment of the physically handicapped. In point of fact, in the kind of group insurance that would result from the mandated purchase of insurance at a worker's place of employment, the cost of including coverage for the physically handicapped would be extremely low, and would not, as has been alleged, discourage employers from hiring the handicapped.

As a final point, proponents of the trust fund approach argue that it is the only way to assure that all persons would have access to the same level of comprehensive benefits. However, several other bills would accomplish this same objective without creating the inflexibility of a single collection and allocation mechanism for most of the health care dollars. We believe universality of coverage for all persons, irrespective of income level, age, or any other such variable, would be made possible by: (1) Mandating or strongly encouraging the availability of health insurance benefits for the employed; (2) extending these benefits to persons who become unemployed; (3) providing statewide pools for group insurance, available to the self-employed, small groups, and uninsurables; (3) assuring coverage for low-income persons through governmental general tax revenues, primarily Federal; and (4) continuing the existing social security tax mechanism for the aged and disabled.

For emphasis, we would reiterate that while funds for coverage of various segments of the population will come from different sources, the benefits would be similar for all persons. Continuity of benefits would be assured. Thus, it is erroneous to assume that a trust fund is the only mechanism that can achieve the important objective of universal and continuous coverage.

We believe, in any national health insurance, you must consider philanthropy. For example, between 1964 and 1973, annual charitable giving for health increased from $1.98 billion to $3.98 billion.

This increase of over 200 percent is greater than that received by religious or educational recipients. Charitable giving paid for over 4 percent of the Nation's total health expenditures in 1973. Philanthropy provided almost 10 percent of the funds used for private. nonprofit health and hospital construction in 1973. Philanthropy provided $220 million for medical research.

These facts demonstrate the importance of philanthropy to the financing of health care and medical research in the past and suggest the calamitous impact that would result if such philanthropy were to be reduced or eliminated in the future.

We believe, therefore, Mr. Chairman, that specific provisions should be included in a national health insurance legislation to protect and encourage private philanthropy for health care under national health insurance. H.R. 1 seeks to do this by language in the "Findings and Declaration of Purpose" section of the bill and by providing that institutions would not be required to use unrestricted gifts, grants, and incomes from endowments for ongoing operational expenditures.

Now, I would like to address the financial requirements that we believe should be included in any national health insurance program. Pages 16 to 19 deal with this in some detail.

The financial requirements of health care institutions vary; so do their financial resources. Collections by health care institutions from all payers must yield sufficient revenues to meet their full financial requirements. Our association defines these requirements as the monetary resources a health care institution must have to fulfill its responsibilities in meeting its community's health service needs.

We believe firmly that any national health insurance bill must spell out the elements of financial requirements for health care institutions in some detail. We recommend that this committee include language in any bill its develops to adequately define institutional financial requirements. Among these most important requirements are the following:

First. Requirements for direct and indirect expenses for patient care services, including such services to indigents with respect to whom payments by or for the patient is waived in whole or in part by the corporation or institution, but reduced by the amount of any grants—including income from endowments—earmarked by the donor or reserved by the governing body of the corporation or institution for payment for such services.

Second. Requirements to defray any deficit of approved education or training programs.

Third. Requirements for minor remodeling of facilities.

Fourth. Requirements for current operating needs—working capital—or to meet contingencies.

Fifth. Requirements for allowable funds for construction replacement, major modernization or expansion of plant equipment and services approved through the planning process and for debt amortization of those projects.

Sixth. Requirements to meet other operating expenses required to meet standards imposed under this act, such as patient education programs.

Seventh. Requirements of specific price level depreciation to establish and perpetuate a revolving fund to meet ongoing expenditures for the purchase of major movable equipment. The AHA favors use of the prospective payment mechanisms under national health insurance and as indicated on pages 18 and 19 of our testimony with the cautions that we have set forth there.

Now a few words about regulation. I call your attention specifically to pages 19 and 21 of our written statement.

The Federal Government must play a pivotal role in any national health insurance program in determining the basic level of health benefits that should be available for all, and how these benefits may progressively be expanded as the system grows, and (2) establishing the scope, standard of quality, and comprehensive of health services. The Federal Government should assure that the responsibilities and administrative structures of State agencies provide a reasonably uniform operation of the regulatory processes throughout the country. The Federal Government should also develop ways to coordinate the activities of all of its agencies concerned with health and health-related programs, as well as those of voluntary organizations with respect to their conduct of approval, accreditation, or certification programs. To this end the American Hospital Association recommends establishment of a separate, cabinet-level Department of Health, with full responsibility for the implementation and coordination of a national health insurance program. It would be aided by a top-level advisory committee made up of consumers and providers.

The health care field is subject to an overabundance of controls, guidelines, audits, surveys, inspections, and regulatory programs originating at all levels of government—Federal, State, and local. Hospitals, especially, are faced with a myriad of regulatory programs, and only on rare occasions are these regulatory activities effectively coordinated. National health insurance could provide an opportunity for the Nation to make some sense of the multitude of overlapping efforts. In fact, we believe that the development of an appropriate regulatory framework is an essential component of a national health insurance program.

The AHA's policy statement includes an effective framework for regulation of health services. It would provide for a balanced process in which the Federal Government would act as a catalyst and monitor for instituting necessary changes.

STATE REGULATION

Under appropriate Federal guidelines, review of provider rates, certification of need and planning activities, utilization controls, and controls over insurance premiums and benefits would be focused at the State and local levels. Such State and local control is essential in order to appropriately reflect social and economic variations from community to community and among the States across the country.

A trend toward State and local mechanisms for the regulation of health services has already surfaced. Legislation to establish a certificate-of-need process has been enacted in 24 States and currently is under consideration in several others. Prospective rate review processes also are in effect or under consideration in a number of States. In addition, Public Law 93–641 calls for implementation of certificate-of-need programs in every State, authorizes experimentation in State rate review and regulation in six States, and emphasizes the responsibilities and role of State and local agencies or organizations in the planning and development of health resources. Another example of delegation of regulatory authority to State and local levels under Federal guidelines is the establishment of professional standards review organizations—PSRO's. Many other aspects of health care regulation and administration are already established at the State level; for example, licensing, facility standards, and carrier regulation. We feel that such regulatory activities in the health field can be carried out more effectively at State and local levels than at the Federal level and that any national health insurance legislation should focus regulatory activities at the State and local levels under Federal guidelines.

Finally, one last matter, Mr. Chairman, that has to do with the implementation schedule of the national health insurance program. It is unreasonable to expect that a new or significantly changed health care delivery system can be brought into being immediately upon the enactment of legislation. Implementation of a national health insurance program which addresses itself to the goal of providing health care to all Americans will be a tremendous and complex task. It is in our view essential that any national health insurance legislation include a phasing-in process, say 5 years, which provides for the development of organizational and professional resources needed to meet this goal.

Finally, Mr. Chairman, the American Hospital Association believes that our recommendations for dealing with the key issues involved offer reasonable and workable solutions to the problems of health care delivery, financing, and regulation, and constitute a program that would meet the Nation's health care needs. We strongly support and commend to the committee H.R. 1, which provides comprehensive health benefits for all Americans; for restructuring of the health care delivery system; for an equitable and adequate financing system and regulatory system to be implemented at State level; and a necessary phase-in period.

We appreciate this opportunity, Mr. Chairman, and members of the subcommittee, to present our views on national health insurance and stand ready to assist the committee further in any way we can as it continues its deliberations.

[The prepared statement follows:]

Statement of the American Hospital Association

SUMMARY OF STATEMENT AND RECOMMENDATIONS

I. Development of AHA Policy.—AHA's *Policy Statement on Provision of Health Services* (1971) and *Summary of Principles for a National Health Insurance Program* (1975) are the product of a detailed study and review of the nation's health care system.

II. Goals and Issues.—The Association's recommendations seek to address the problems facing the health care system which are summarized under three headings: *Uneven access* to services; *Rising costs* of health care; and *Regulatory fragmentation.*

The AHA *Policy Statement* calls for a national health insurance program that would:

Provide universal coverage for all Americans with comprehensive benefits, including coverage of catastrophic illness expenses;

Provide equitable and adequate financing from multiple sources of funds, both governmental and private;

Provide for integration and coordination of all elements of the health care delivery system, including its organization, financing, and regulatory/administrative structures;

Provide for preservation and encouragement of philanthropy in the health field;

Provide assurances that care will be available, accessible and acceptable to consumers and providers; and

Provide means of ensuring high quality health care is rendered in the most economical manner.

The AHA strongly supports H.R. 1, The National Health Care Services Reorganization and Financing Act, introduced by Rep. Al Ullman, Chairman of the House Committee on Ways and Means, which addresses these goals and issues.

III. Coverage and Basic Benefits.—The objective is to make a high level of comprehensive health benefits available to all persons, without distinction between benefits for acute physical and acute mental illness, provided in the most economical manner, and with only modest copayments. We strongly support the "health card" approach in H.R. 1.

IV. Catastrophic Benefits Coverage.—We believe coverage of expenses of catastrophic illness should be made available to all persons as part of a comprehensive national health insurance benefits package, rather than as a separately financed and administered benefit. The reasons for this view are set forth in detail in the statement.

V. Development of Health Resources.—No national health insurance program should promise more than it can deliver and governmental support should be provided to assist in the development of the necessary facilities and services to meet the increased demand for services that will inevitably come under any NHI program.

VI. Health Delivery System.—The AHA has developed the Health Care Corporation (HCC) concept which is embodied in H.R. 1, and is described in our statement. HCCs would be community-based, not-for-profit, private or governmental organizations to synthesize and improve local health resources to deliver comprehensive health care to the populations of defined geographic areas.

VII. Financing Health Care Services.—*We recommend the utilization of multiple sources of financing* (Federal general tax revenues, Federal taxes collected through the Social Security mechanism, employer-employee health insurance premium payments, and individual out-of-pocket expenditures) to finance a national health insurance program. There should be adherence to the principle that all who are able to do so will contribute to the cost of their health care.

We do not favor the trust fund approach as the single collection and allocation mechanism for health care dollars for we believe it would create inflexibility in development and underwriting of health insurance tailored to the specific needs of a particular group and to local needs; would involve higher administrative costs (a recent GAO study supports this point); and if income is less than actually required to meet beneficiaries' needs, the program would become a bureaucratic "rationer" of services, and such a shortfall would place providers in an untenable position that could only lead to a general reduction of services or to bankruptcy.

Philanthropy continues to be very important in the financing of health care services and facilities and specific provisions should be included in any national health insurance to protect and encourage charitable giving in the health field.

VIII. Financial Requirements.—We believe any national health insurance legislation should spell out the elements of financial requirements of health care institutions and provide for meeting such requirements. We suggest specific language to accomplish this. We favor development by the states of optional prospective payment mechanisms under Federal guidelines based on budget review, target rates, negotiations with third parties, or other appropriate methods.

IX. Regulation.—National health insurance legislation provides an opportunity to coordinate and make some sense from the multitude of overlapping, confusing and often conflicting regulatory controls and programs in the health care field which come from all levels of government. We recommend the establishment of a separate, cabinet-level *Department of Health* with full responsibility for implementation and coordination of a national health insurance program and other health activities of the government.

The Federal role should be directed toward determining the basic level of health benefits and establishing standards of quality, with control mechanisms that are implemented at the state level.

The regulatory role of states should extend to review of provider dates, certification of need and planning activities, utilization review, and controls over insurance premiums, carried out under appropriate Federal guidelines. Delegation of regulatory functions to state and local agencies is essential to respond to wide variations in social, economic, and other factors from community to community and from state to state across the country.

X. Implementation.—Implementation of any national health insurance program will be a tremendous and complex task, and a phasing-in process is, in our view, essential.

CONCLUSION

The AHA believes our recommendations would lead to reasonable and workable solutions to the major problems of health care delivery, financing, and regulation, and constitute a program that would meet the nation's health care needs. We strongly support and commend to the Committee H.R. 1, The National Health Care Services Reorganization and Financing Act.

STATEMENT

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me is Leo J. Gehrig, M.D., Senior Vice President of the Association, who heads our Washington Office.

The Association's membership, which consists of some 7,000 member institutions including most of the hospitals of the country, extended long-term care institutions, mental health facilities, and hospital schools of nursing, is deeply committed to providing high quality health care to all people at a reasonable cost. We welcome this opportunity to testify before your Committee on national health insurance and to express our views on the crucial issues of organizing, delivering and financing the delivery of health care services to meet the nation's health care needs.

DEVELOPMENT OF AHA POLICY

The American Hospital Association has developed a broad framework for a system of organizing, delivering, financing, and regulating health services that is embodied in the Association's *Policy Statement on Provision of Health Services* (1971), a copy of which is attached. This statement is the product of efforts that began some six years ago with a detailed study and review of the nation's health care system by a special committee named by the Association's Board of Trustees to determine how the system might be made more effective and more comprehensive, and provide better health services for all people. Earlier this year the principal elements of the *Policy Statement* were reaffirmed in the attached *Summary of Principles for a National Health Insurance Program* (1975).

GOALS AND ISSUES

Before enumerating the specific goals we believe any national health insurance program should achieve, let me say that the Association in formulating its recommendations sought to address the major problems facing the health care system. In general terms these problems can be summarized under three headings.

Uneven access to health care services.—Adequate and equitable access to health care is precluded for many people for a variety of reasons, for example, shortages and maldistribution of manpower and facilities; lack of coordination by health care providers and planners; and inadequate financial resources to pay for needed services. There are also social and educational barriers which prevent people from seeking care, even when such care and the financial resources to pay for it are available.

Rising costs of health care.—This is a major concern because of the burdens that rising costs place on the public generally. Increases in the cost of health care fall directly on self-pay patients, necessitate higher premiums for hospital insurance in order to preserve existing benefits and add to the cost of the Medicare, Medicaid and other government programs. Unfortunately, the real causes of rising costs are not well understood by the public. While inflation is responsible for about 50 percent of the increase in health care costs, an equally important factor has been the changing character of health services resulting from new and expanded services to provide better care for patients.

Regulatory Fragmentation.—Health care providers are subject to a host of regulations, guidelines, standards, audits and surveys promulgated or conducted by professional and accrediting groups and by various agencies of local, state and federal governments. These regulatory activities are often duplicative and conflicting.

While much has been accomplished by the health care system in recent years in striving to overcome these problems, and while the system has made a commendable response to the demands placed on its resources by the Medicare and Medicaid programs, we all know that the problems have not been solved. All these persistent health care problems must be carefully addressed in the development of a national health insurance program.

Identification of the specific goals to be achieved by a national health insurance program is essential to set a basis for evaluating the specific proposals found in various bills. We believe that in order to provide a workable solution to the problems we face in the delivery of health care and in the financing and regulation of the health care delivery system, the program should:

Provide universality of coverage for all Americans through comprehensive health benefits, including inpatient and outpatient services and coverage for catastrophic illnesses;

Provide for equitable and adequate financing for multiple sources of funds, both governmental and private;

Provide for integration and coordination of all key elements of the health care system, including the means for delivering health services, the mechanisms for financing and payment for services, and the regulatory and administrative structures;

Provide for preservation and encouragement of philanthropic giving for health care facilities and services;

Provide for a better organized, more productive health care delivery system to assure that care is available, accesible and acceptable to both consumers and providers; and

Provide appropriate means to ensure the rendering of high quality health care in the most economical manner.

Our Association has outlined a comprehensive national health insurance program which could be a lever to improve the structure of the system, increase the accessibility of high quality care, bringing some relief from duplicative and conflicting regulatory actions, and assure equitable and adequate financing for health care services. Implicit in our outline, which I shall now describe for you, is our strong belief that to be viable national health insurance legislation must address the major issues and problems within the health care system and provide for an integrated and coordinated program. We do not believe that a piecemeal approach is advisable. We believe it will not work, and that a legislative program which addresses only some of the problems can only further exacerbate and perpetuate a continued fragmentation of health care services.

H.R. 1, The National Health Care Services Reorganization and Financing Act, introduced by Chairman Al Ullman of the House Committee on Ways and Means incorporates provisions which appropriately address the key issues the American Hospital Association believes must be dealt with in any national health insurance program. The AHA strongly supports that bill.

COVERAGE AND BASIC BENEFITS

Coverage.—One of our important objectives is to make a high level of comprehensive health care benefits available to all persons—the employed and the unemployed; the aged and the young; the disabled and the well; and persons of all income levels, including the poor and the near-poor. With national health insurance we can and should close the gaps in the current health insurance system through provisions for those who become unemployed, and through special means of coverage for the self-employed, small groups, and "uninsurable" segments of the population. Thus, through various sources and methods, a uniform level of benefits for all persons would be assured, irrespecitve of income category, age, employment status, or other such variables.

Benefits and Cost-Sharing.—The benefits package of any national health insurance program should be comprehensive and include such components as are needed to maintain personal good health and to prevent illness; provide primary, specialty, restorative and health-related custodial care; cover all illnesses including catastrophic; and make available health services in ambulatory and institutional settings depending on the needs of the patient.

The AHA recommends that no distinction be made between benefits for acute physical and benefits for acute mental illness. Recent studies, including one conducted by the AHA,[1] have shown that acute mental illness benefits are insurable at a reasonable cost and that there are no substantial grounds for providing a relatively limited level of acute mental illness benefits in national health insurance. In fact, there are many sound arguments for coverage equal to that provided for other illnesses.

It should be noted that some national health insurance bills are not limited to medical benefits but would also be directed to health-related social problems of the disabled and the elderly. As a consequence, these provisions and their overall financial implications should be carefully studied.

The imposition of a substantial cost-sharing requirement through deductibles and high copayments in the benefits package recommended in some national health insurance bills concerns us in two ways. First, there is too high an administrative cost in implementing a deductibles program. The cost of administering such a deductibles provision will be found to be substantial as compared to the dollars saved through the use of deductibles. Second, a high level of deductibles and copayments could become a barrier to individuals seeking or receiving needed health care services. The out-of-pocket expenditures required to meet the deductibles could well discourage some individuals from obtaining needed care, as could the relatively high copayment provisions in some proposals. We do not believe that deductibles or high copayments are the most effective means for controlling over-use of medical services since much of medical care use is not determined by the patient, but we believe that some cost sharing is both appropriate and desirable. The best approach to achieving equitable cost sharing would be through modest copayments, rather than deductibles and properly constructed utilization reviews are the appropriate means for preventing over-use.

We strongly support the "health card" approach that is included in H.R. 1 and a number of other NHI proposals as an important mechanism for reducing barriers to care and for increasing the administrative efficiency in the overall payment system. The concept provides for issuance of a health card to each covered beneficiary. This card would be evidence of eligibility for care and would provide for copayments first being paid by the insurance carrier and settled subsequently between the carrier and the patient. This system would eliminate a patient's need for cash at the time of service, would eliminate any "means test" at that time and would transfer the collection function from the provider to the carrier, thus simplifying administration of the program. The development of a mechanism such as this is sorely needed, and is a function that insurance carriers can effectively perform.

CATASTROPHIC BENEFITS COVERAGE

We believe that any national health insurance program should provide coverage for the expenses of catastrophic illness. However, we firmly believe that catastrophic coverage must be made a part of a comprehensive benefits package that would be made available to all persons, rather than be a separately financed and administered benefit because:

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[1] *Financing Mental Health Care in the United States—A Study and Assessment of Issues and Arrangements.* Published by the National Institute of Mental Health, 1973. Available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

At the present time, 80 percent of the people in this country have insurance coverage for hospital services. A separate catastrophic coverage program could duplicate much of this coverage and merely lead to a downward revision of some private employer-employee health insurance policies to conform to the separate catastrophic program.

The catastrophic coverage programs that have been proposed do not incorporate support for improvements in the health care delivery system that are needed if national health insurance is to be successful.

The separation of catastrophic coverage from the basic benefits coverage would create additional administrative expense in the health insurance system. There would be duplicative record keeping and claims processing requirements if a substantial portion of the population had basic coverage underwritten by private insurance carriers through employer-employee groups and catastrophic coverage under a government program. Under these circumstances, many benefits claims would have to be processed both under the basic coverage and under the catastrophic coverage. The administrative expense of doing so and of determining where liability rests would be substantial.

Separation of catastrophic coverage from the basic benefits package would create an undesirable rigidity in the system in that private carriers would not be free to develop broad benefits packages that could be adapted to the special needs of various insured groups. In contrast, by requiring comprehensive benefits but allowing maximum flexibility in the design and adaptation of insurance coverage in the private market, substantial advantage can accrue in the form of broader coverage for the same price, or lower prices for the basic level of benefits.

A solely tax-supported catastrophic program would be duplicative in many instances because it would provide benefits that many employers and individuals are now paying for voluntarily, either through group or individual health insurance coverage.

Use of Social Security mechanisms to finance all catastrophic benefits could expand the use of Medicare retrospective cost reimbursement formula, a mechanism that lacks incentives for efficiency and is inequitable in its failure to bear fully the appropriate share of hospital costs for program beneficiaries.

Also, there are several important deficiencies in the Medicare benefits package, such as the heavy emphasis on acute inpatient services, the lack of outpatient drug coverage, very restricted health maintenance benefits, the split between Parts A and B, and the use of high deductibles and copayments, that should be addressed in national health insurance but that would be perpetuated and compounded if a catastrophic benefits program were superimposed on the existing Medicare benefits package.

DEVELOPMENT OF HEALTH RESOURCES

When a national health insurance program providing comprehensive benefits to all is enacted, there is certain to be an increased demand on health care facilities and services. To meet this added demand, the health care delivery system will need a greater capability, especially for providing outpatient or ambulatory care services. Authorized benefits must be matched with available and accessible services. A program should not be enacted that promises more than it can deliver. Some of the added services can be provided by using our resources more effectively rather than through an expansion of resources. To this end, support will be required for the development of new, more effective forms of health care delivery and to encourage the growth of existing effective delivery organizations and to strengthen many of the progressive moves already taking place in the field, such as mergers, formation of multiple facility organizations and arrangements for shared services.

It is essential that national health insurance legislation include provision for health resources development in such areas as health systems, manpower, facilities, communications, and transportation. Further, such provision should be coordinated with other programs to assist in the development of health resources. H.R. 1 seeks to do this and calls for a special study for the development of a program to provide other funds for resources to meet high priority health service needs in underserved rural or urban areas.

HEALTH DELIVERY SYSTEM

Support for the development of needed health resources comes into even sharper focus when we examine the issues and problems now confronting our health delivery system. While it is critical to develop a benefits package that is as comprehensive as possible for the total population, there also should be assurances that the actual services to provide these benefits will be available and accessible. It is our assessment that the existing system could not fully respond immediately to the increased demands that will inevitably follow the enactment of national health insurance legislation, but we believe firmly that the private sector can and will meet the nation's health care needs, given appropriate support for development of the needed resources.

To do so, however, existing institutional and professional providers of health care services will need to improve greatly the coordination of and access to comprehensive health care services. We believe that the AHA in its policy statement has developed an innovative approach to resolving these issues through the Health Care Corporation (HCC) concept. This concept is incorporated in H.R. 1.

Definition of the HCC.—HCCs would be community-based, not-for-profit, private or governmental organizations that would synthesize local health resources for the delivery of comprehensive health services to defined population groups to better meet the health care needs of the community. HCCs would serve specified geographic areas and provide comprehensive health services through their own facilities and/or through affiliations with other providers, not-for-profit and for-profit.

Every HCC would have to make available high quality comprehensive health services to all persons residing in its service area who would wish to be HCC registrants. These services would range from health maintenance coverage through services for catastrophic illness, and would be provided through the use of the outpatient or inpatient facilities most appropriate to the patients' needs.

HCCs could span political boundaries where necessary to assure that all persons have access to care. They would extend services into underserved areas, both rural and urban, thus providing an important link to a comprehensive health care system for individuals residing in these areas and also for health care professionals presently isolated from the mainstream of the system. The goal of the HCC concept as contained in H.R. 1 is to bring about the establishment of HCCs in all areas of the country. This would provide the public an opportunity to choose between the services of these comprehensive health delivery organizations and the traditional patterns of care. In some areas there would be the further possibility of selection among several HCCs.

How HCCs Would Help Meet Problems of the Delivery System.—The HCC concept offers an opportunity to take significant steps toward solving two major problems of the health care delivery system—the need for assured access to a comprehensive level of health care for all persons, and the need for greater coordination of services.

Access to care which is a serious problem today will become an even more critical problem when broad scale benefits and financing for them are extended through national health insurance to the entire population. We believe that the geographic responsibility of the HCC is a realistic approach with substantial promise for assuring that services would be available to all.

HCCs, like HMOs, would be responsible for providing a comprehensive range of services for all of its registrants, so that from the consumer's viewpoint, a single, identifiable and accountable organization would be responsible for meeting all of his health care needs. Thus, an important element for coordinating for the patient appropriate modalities of care, including both physician and institutional services, would be established.

Moreover, coordination and planning of services on a local, state, and national basis, can be improved through implementation of this concept. The HCC approach through its responsibility for a specified geographic area would result in a truly nationwide system for the delivery of comprehensive services, in contrast to the HMO concept, since each area of the nation would be covered by at least one HCC within a reasonable period of time. This would be accomplished through the combination of HCC development and planning for a geographically defined population group and a state-based regulatory process to assure that all areas would be covered within each state without unnecessary duplication of facilities or services.

The details of the HCC concept and system can be found in Part II (pages 4–9) of the AHA *Policy Statement*. This concept would move toward resolution of major problems in the delivery of health services in vital ways and should be seriously considered for inclusion in any legislation for national health insurance.

FINANCING HEALTH CARE SERVICES

We believe that all persons should be assured of financial access to health care and that no person should be denied health care because of inability to pay. We also believe that there should be adherence to the principle that every person who is able to do so should contribute to the cost of his health care.

Sources of Funds

To achieve the dual objective of equity in the distribution of the financial burden and effectiveness in the raising of funds, multiple sources of funds should be utilized to finance a national health insurance program, including general federal tax revenues, federal taxes collected through the Social Security mechanism, premium payments by employers and employees, and individual out-of-pocket expenditures. The goal here is that every person who is able to do so should contribute. Further, we believe that health care dollars should flow from these multiple sources to health care providers to help assure the delivery system's responsiveness to local needs. Private contributions play an important role in the health field and help to assure that services will be responsive to local needs. Such contributions should be encouraged.

Some national health insurance proposals would rely primarily on a single financing mechanism—a new federal trust fund supported by payroll taxes and general tax revenues. Other bills would utilize the existing Medicare trust fund and expand on its base. We have several concerns with the reliance on a trust fund approach in whatever form:

1. It would create inflexibility in the development and underwriting of health insurance benefits by (a) sharply reducing the savings that accrue from competition by carriers for employer group health insurance business, savings that currently exist in the form of broader benefits for the same price or a lower price for the same level of benefits; and (b) by restricting the opportunities for savings which are possible in the tailoring of a health insurance package to the specific needs of a particular group.

2. The manpower, facilities, and equipment that would be required to administer a national health insurance program through one governmental agency for over 200 million persons staggers the imagination. Although some advocates of the trust fund approach suggest that this mechanism can provide economies, principally through centralized administration, there is no conclusive evidence to suggest that the federal government can do a more efficient job than private carriers in administering a broad scale program. In fact, in a study ordered by the House Ways and Means Committee the General Accounting Office has found it costs the government nearly twice as much as it costs private insurance carriers to process each Medicare claim. To dismantle a substantial portion of the existing machinery in the private market to no productive purpose makes no sense to us. These resources can and should be utilized to the fullest extent.

3. The trust fund approach would require the assessment of the needs of the group served, a difficult, if not impossible, task when that group consists of more than 200 million people. Subsequent to need assessment, moreover, would be the problem of establishment of a tax rate and tax base to generate the required level of revenue to meet this need. The "pegging" involved would be extremely complex, but even more complicating would be the consequence of underestimating the needs, for if the number of dollars required to actually meet the health care needs for the nation turn out to be greater than the amount projected and made available, the trust fund would become the indirect rationer of health care. Certain individuals would then be forced to forego needed health services and health care providers would be forced to cut back services, or operate at a deficit, or both. Other negative consequences could occur because:

a. A trust fund subject to underfinancing would channel revenue on the basis of presumptive priorities. For example, an abnormal share of payments would have to be channeled to certain services, or classes of providers, or classes of patients. This channeling would be done on the basis of priorities decided by the fund's administrators, whether or not those priorities coincide with the widely varying needs of beneficiaries in all parts of the country. If the bureaucratically established priorities were askew, the basic underfinancing problem would be further aggravated by the misallocation of scarce funds.

b. A trust fund, falling short of participants' needs, would create a gap between reimbursed benefits and the actual financial requirements for providing the needed services, and place the provider in an untenable position. On the one hand, payments from the trust fund would fall short of the cost of service, and on the other, the consumer could not be billed for the difference. A deficit problem would be created for providers that could only lead to a general reduction in service or to bankruptcy.

4. Another consequence of the trust fund system would be the inequity created through imposing taxes for health insurance on individuals and on employers that bear no relation to the number of beneficiaries covered, or to the actual utilization of services by the worker or his family. Under the typical trust fund proposal, a wage earner who is single would pay the same amount as a married coworker with identical earnings and a large family, and the taxes paid would bear little direct relationship to the insurance value received.

5. Some have argued that the trust fund approach would remove a disincentive for employment of the physically handicapped. In point of fact, in the kind of group insurance that would result from the mandated purchase of insurance at a worker's place of employment, the cost of including coverage for the physically handicapped would be extremely low, and would not, as has been alleged, discourage employers from hiring the handicapped.

As a final point, proponents of the trust fund approach argue that it is the only way to assure that all persons would have access to the same level of comprehensive benefits. However, several other bills would accomplish this same objective without creating the inflexibility of a single collection and allocation mechanism for most of the health care dollars. We believe universality of coverage for all persons, irrespective of income level, age, or any other such variable, would be made possible by:

Mandating or strongly encouraging the availability of health insurance benefits for the employed;

Extending these benefits to persons who become unemployed;

Providing statewide pools for group insurance, available to the self-employed, small groups, and uninsurables;

Assuring coverage for low-income persons through governmental general tax revenues, primarily federal; and,

Continuing the existing Social Security tax mechanism for the aged and disabled.

For emphasis, we would reiterate that while funds for coverage of various segments of the population will come from different sources, the benefits would be similar for all persons. Continuity of benefits would be assured. Thus, it is erroneous to assume that a trust fund is the only mechanism that can achieve the important objective of universal and continuous coverage.

Philanthropy

Philanthropy has been and continues to be a very important factor in the financing of health care services. Consider the following:[2]

Between 1964 and 1973, annual charitable giving for health increased from $1.98 billion to $3.98 billion.

This increase of over 200 percent is greater than that received by religious or educational recipients.

Charitable giving paid for over 4 percent of the nation's total health expenditures in 1973.

Philanthropy provided almost 10 percent of the funds used for private, nonprofit health and hospital construction in 1973.

Philanthropy provided $220,000,000 for medical research in 1973.

These facts demonstrate the importance of philanthropy to the financing of health care and medical research in the past and suggest the calamitous impact that would result if such philanthropy were to be reduced or eliminated in the future.

The AHA believes specific provisions should be included in a national health insurance legislation to protect and encourage private philanthropy for health care under national health insurance. H.R. 1 seeks to do this by language in the

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[2] Source: 1. *Giving USA,* 1974 Annual Report, American Association of Fund Raising Counsel, Inc. 2. *Hospitals, J.A.H.A.,* July 1, 1974.

"Findings and Declaration of Purpose" section of the bill and by providing that institutions would not be required to use unrestricted gifts, grants, and incomes from endowments for ongoing operational expenditures. Of course, the bill does provide that philanthropic funds which are to be used for capital purposes would be subject to the certification of need process. This last provision is designed to assure that philanthropic funds will not be used for non-approved facilities or services, but, like all other resources development funds, must be subject to the health planning process and certificate of need laws.

Financial Requirements

Because health care institutions are located in and serve every conceivable kind of community, and because such institutions themselves differ in size, scope, and the types of services they provide, their financial requirements vary. So does their ability to underwrite services for nonpaying patients. Collections by health care institutions from all payors must yield sufficient revenues to meet their full financial requirements. Our Association defines these requirements as the monetary resources a health care institution must have to fulfill its responsibilities in meeting its community's health service needs.

We believe firmly that any national health insurance bill must spell out the elements of financial requirements for health care institutions in some detail. We strongly recommend that this Committee include language in any NHI bill it develops to adequately define institutional financial requirements. Suggested language is as follows:

The method or methods to be used, and the elements to be considered, in determining the financial requirements of hospitals and other health care institutions shall be prescribed by regulations and shall include—

1. requirements for direct and indirect expenses for patient care services, including such services to indigents with respect to whom payment by or for the patient is waived in whole or in part by the corporation or institution, but reduced by the amount of any grants (including income from endowments) earmarked by the donor or reserved by the governing body of the corporation or institution for payment for such services;
2. requirements to defray any deficit of approved education or training programs;
3. requirements for minor remodeling of facilities;
4. requirements for current operating needs (working capital) or to meet contingencies;
5. requirements for allowable interest on funds borrowed;
6. requirements to meet other operating expenses required to meet standards imposed under this Act, such as patient education programs;
7. requirements of specific price level depreciation to establish and perpetuate a revolving fund to meet ongoing expenditures for the purchase of major movable equipment;
8. requirements of general price level depreciation on other plant and equipment facilities for the maintenance and preservation of the corporation's or institution's assets;
9. requirements for prospective accumulation of funds or current payments for construction, replacements, major modernization, or expansion of plant. equipment, and services, approved by the planning process, and debt amortization of these projects in those years when the expenditures for those projects exceed the sum of depreciation payments under items 7 and 8 provided that the corporation or institutions makes assurances to the state health commission (as provided in H.R. 1) that the total payments for these financial requirements over the life of the facilities will not exceed their general price level depreciation charges;
10. requirements for a return on total assets employed in the provision of institutional health services, with the Secretary determining annually a reasonable rate of return and with such rate for an institution being no less than the interest rate paid by the institution on its debt capital.
11. requirements needed to provide a margin of safety before the institution is paid on a prospective rate basis and in any given period there is a risk that the prospective rate will yield revenues that are below costs so that a reserve to meet such a contingency is necessary.

Payment of Providers of Service

Throughout the nation, institutional health care providers are being paid for their services under a variety of systems, ranging from retrospective cost-based reimbursement to prospective payment systems. Some of the prospective approaches are quite new and the various approaches are still being evaluated. The Department of HEW reported that as of March 1974 there were 26 prospective payment systems in existence in 22 states, involving approximately 25 percent of the nation's hospitals. As indicated in the following table, HEW's report identifies three general categories of prospective systems, each of which may use any of four general bases for determining reasonableness of rates and any of four different units of payment.

Summary of rate-setting methodology of developed prospective rate systems [1]

	Number of programs
System basis:	
Budget approval	11
Charge increase review	11
Formula	4
Basis for determining reasonableness:	
Institutional Comparison	14
Cost history only	10
Formula	2
Normative standards only	0
Unit of payments:	
Charges	15
Per diem	6
Budget allocation	3
Per admission	1
Experiment testing several methods	1

[1] Source: "Analysis of State and Regional Health Regulations." Human Resources Administration, Department of HEW. DHEW Publication No. (HRA) 75–611.

The American Hospital Association favors use of the prospective payment mechanism under national health insurance. On the other hand, because of the variety of approaches available within this "prospective" label, and because of the relative newness of these approaches, it appears premature to mandate in any national health insurance law the use of a single specific method of prospective payment to institutional providers of services. Therefore, it is our view that any national health insurance program should provide for the establishment, after consultation with hospitals and others, of one or more payment methods within each state. Payment methods that are to be developed on a state-by-state basis, in accordance with regulations of the Secretary, could be based on budget review, target rates, negotiation with third parties, formula or other appropriate methods. States should be permitted to develop more than one system and where this occurs, providers should have the option of selecting from the alternatives. Once a system or systems were established in a state, they would apply uniformly to all payers, including the federal government.

Inherent in any prospective payment system is the possibility that estimates of activity may not be realized and that estimates of cost trends may be exceeded. It is, therefore, important that the service continuity of hospitals not jeopardized by unpredictable changes in utilization, revenues, or costs. A reasonable operating margin will provide the needed flexibility to meet such potential developments and help avoid recourse to alternate high-cost capital such as short-term borrowing, and it offers sources for developing equity funds for improvement of services, subject, of course, to planning approvals.

REGULATION

The Federal Role

The federal government must play a pivotal role in any national health insurance program, with efforts directed toward (1) determining the basic level of health benefits that should be available for all, and how these benefits may progressively be expanded as the system grows, and (2) establishing the scope, standards of quality, and comprehensiveness of health services. Although we believe that control mechanisms are best implemented at the state level rather than federally, the federal government should assure that the responsibilities and administrative structures of state agencies provide a reasonably uniform operation of the regulatory processes throughout the country. The federal government should also develop ways to coordinate the activities of all of its agencies concerned with health and health-related programs, as well as those of voluntary organizations with respect to their conduct of approval, accreditation, or certification programs. To this end the American Hospital Association recommends establishment of a separate, cabinet-level Department of Health, with full responsibility for the implementation and coordination of a national health insurance program. It would be aided by a top-level advisory committee made up of consumers and providers.

The health care field is subject to an overabundance of controls, guidelines, audits, surveys, inspections and regulatory programs originating at all levels of government—federal, state, and local. Hospitals, especially, are faced with a myriad of regulatory programs, and only on rare occasions are these regulatory activities effectively coordinated. National health insurance could provide an opportunity for the nation to make some sense of the multitude of overlapping efforts. In fact, we believe that the development of an appropriate regulatory framework is an essential component of a national health insurance program.

The AHA's *Policy Statement* includes an effective framework for regulation of health services. It would provide for a balanced process in which the federal government would act as a catalyst and monitor for instituting necessary changes.

State Regulation

Under appropriate federal guidelines, review of provider rates, certification of need and planning activities, utilization controls, and controls over insurance premiums and benefits would be focused at the state and local levels. Such state and local control is essential in order to appropriately reflect social and economic variations from community to community and among the states across the country.

We believe that through the delegation of regulatory functions to state and local agencies a process can be developed that would be more truly responsive to the real needs within each community. Extensive, complex federal controls would be inflexible and inadequate in view of the diverse and highly varied nature of communities and the ways in which they choose to meet their health care needs. What works well in a densely populated urban area won't always work well in a small town located in a rural area.

Competition on a controlled basis should be built into the system to maintain the system's viability, to stimulate efficiency and preserve the independence so vital to innovation, and to assure that local preference and precedence will be protected.

A trend toward state and local mechanisms for the regulation of health services has already surfaced. Legislation to establish a certificate-of-need process has been enacted in 24 states and currently is under consideration in several others. Prospective rate review processes also are in effect or under consideration in a number of states. In addition, P.L. 93–641 calls for implementation of certificate of need programs in every state, authorizes experimentation in state rate review and regulation in six states, and emphasizes the responsibilities and role of state and local agencies or organizations in the planning and development of health resources. Another example of delegation of regulatory authority to state and local levels under federal guidelines is the establishment of Professional Standards Review Organizations (PSROs). Many other aspects of health care regulation and administration are already established at the state level, for example, licensing, facility standards, and carrier regulation. We feel that such regulatory activities in the health field can be carried out more effectively at state and local levels than at the federal level and that any national health insurance legislation should focus regulatory activities at the state and local levels under federal guidelines.

IMPLEMENTATION OF NATIONAL HEALTH INSURANCE

It is unreasonable to expect that a new or significantly changed health care delivery system can be brought into being immediately upon the enactment of legislation. Implementation of a national health insurance program which addresses itself to the goal of providing health care to all Americans will be a tremendous and complex task. It is in our view essential that a national health insurance legislation include a phasing-in process which provides for the development of organizational and professional resources needed to meet this goal. For example, the development of needed health care facilities and services could begin immediately, including support for the establishment of new delivery organizations and outpatient centers. As adequate resources are developed and as a restructuring of the delivery system takes place in the early years of the program, benefits could be phased-in, both in scope and in application to various population groups. At the same time, the development of new state-based regulatory systems could proceed so that all of these forces could converge after a reasonable period of say five years for the full implementation of the program.

CONCLUSION

In conclusion, Mr. Chairman, the American Hospital Association believes that our recommendations for dealing with the key issues involved offer reasonable and workable solutions to the problems of health care delivery, financing and regulation, and constitute a program that would meet the nation's health care needs. We strongly support and commend to the Committee H.R. 1, which provides comprehensive health benefits for all Americans; for restructuring of the health care delivery system; for an equitable and adequate financing system and regulatory system to be implemented at state level; and a necessary phase-in period.

We appreciate the opportunity to present our views on national health insurance and stand ready to assist the Committee further in any way we can.

Summary[3] of Principles for a National Health Insurance Program

APPROVED BY AMERICAN HOSPITAL ASSOCIATION, FEBRUARY 1, 1975

General

A national health insurance program should tie together in an integrated and coordinated fashion all key elements in the health care system—including the health delivery system, the financing mechanisms, and the regulatory and administrative mechanisms.

The program should mandate a comprehensive benefits package, including catastrophic health benefits, to be available to all persons, financed through a variety of sources.

The program should allow sufficient time between enactment of legislation and the actual implementation of its provisions to ensure that adequate delivery systems resources and regulatory structures will be in place.

Health Delivery System

The program should ensure access to health care for all persons and should ensure that the comprehensive benefits of the program are provided to beneficiaries. Such access and availability could be ensured by the development of community-based Health Care Corporations, organizations with the capacity and responsibility to provide comprehensive health care to a population group in a defined geopraphic area.

The program should ensure good quality care. The achievement of quality within the institution should be through utilization review and medical audit performed at the institutional level in a process that places primary responsibility on members of the medical profession who practice in the institution as members of organized institutional medical staffs.

The program should utilize privately developed and operated organizations such as the Joint Commission on Accreditation of Hospitals in determining the institutional and profesisonal providers eligible to participate in the program.

Role of Government

There should be a balanced regulatory mechanism coordinating the roles of both federal and state governments.

The federal government's role should be one of coordinating the program through establishment of broad federal standards and guidelines which should be implemented at the state level, including state prospective rate review and certification of need processes.

A sound comprehensive health planning process at the local and state levels should be incorporated into the program. The basic planning process should be separate from the regulatory process, but should serve as a basis for certification of need decisions in the program.

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[3] Based on established AHA policy including the *Policy Statement on Provision of Health Services*, the *Statement on the Financial Requirements of Health Care Institutions and Services*, the *Policy on the Implementation of the Statement on Financial Requirements*, and other related AHA policies and guidelines.

There should be advisory councils at the federal and state levels with adequate provider representation.

Financing

There should be a pluralistic system of financing health services, using a variety of sources to support a comprehensive level of benefits for all persons. Employers on a cost-sharing basis with employees should be mandated to provide comprehensive health benefits to all employees. Self-employed persons and others should also have access to group insurance coverage. The payroll tax mechanism should not be expanded to finance health benefits.

The program should ensure that philanthropic assistance to the health care field is both maintained and encouraged.

Payments to institutional providers should be based on rates that are prospectively established to reflect total financial requirements. The program should specify the elements of financial requirements including an adequate recognition of the need for institutions to maintain an operating margin.

Blue Cross and Blue Shield plans and private insurance carriers should continue to play a role in underwriting employer/employee contracts, as well as other administrative roles for governmental programs.

There should be federal financial support and incentives to states for their new roles and to organizations forming community-based comprehensive delivery systems.

Every person if able should contribute to the cost of his health care, but no person should be denied access to health care because of inability to pay, and no person should be made financially destitute because of illness.

POLICY STATEMENT ON PROVISION OF HEALTH SERVICES

Approved by House of Delegates
August 24, 1971

AMERICAN HOSPITAL ASSOCIATION
840 North Lake Shore Drive Chicago, Illinois 60611

FOREWORD

The statement set forth in these pages is the official policy position of the American Hospital Association on the provision of health services. The first step in the active development of this policy was the appointment of a special committee to study this matter. The committee was given a broad charge and submitted its recommendations to the Board of Trustees in November 1969. The Board studied those proposals and recommended that the concept be adopted in principle by the House of Delegates. The House took this action on January 27, 1970.

The Board recognized that more detailed study of such a sweeping proposal was necessary before the Association could take final action and a second special committee was named by the Board to receive comments from the membership and other interested bodies. This committee, in turn, made recommendations to the Board of Trustees. After detailed analysis, the Board proposed to the House of Delegates adoption of the policy statement printed herewith. The House debated the matter at its meeting in Chicago and on August 24, 1971 approved the policy statement.

This is now the official policy and supersedes all other Association statements on this subject.

EDWIN L. CROSBY, M.D.
Executive President

JACK A. L. HAHN
President

October 1971

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Part I

GOALS AND PROGRAMS

As a nation we must provide better quality, more convenient health care for all the people, at reasonable cost, and in a manner in keeping with human dignity. This must be done because we accept one basic, irreducible principle:

> Health care is an inherent right of each individual
> and of all the people of the United States.

(1) it is a function of health care to enhance the dignity of the individual and to promote better community life for all;

(2) it is a function of government to assure the preservation and maintenance of the health of all the people;

(3) each individual shares the responsibility for protecting his own health and for obtaining health care when required;

(4) health care must be available without regard to any person's ability to pay and without regard to race, creed, color, sex, or age;

(5) health services must be so organized and located that they are readily accessible to all.

This basic principle and its corollaries can be best and most rapidly implemented through a new nationwide system for the delivery of health services, uniting all the health resources of the United States for better care.

The following specific goals are endorsed:

1. A system for the delivery of health services must be developed which has as a primary objective the optimum health care of each and every person. Untreated illness in the community must be sought out and treated.
2. The system for the delivery of health services must focus on individual needs, must be personalized through the skills and

humanity of health personnel, and must preserve the dignity of the individual.

3. The system for the delivery of health services must assure that no person becomes financially dependent or suffers loss of dignity as a result of illness or accident.

4. The system must assure that all children are provided with preventive health care and that no child suffers from untreated illness.

5. The system for the delivery of health services must provide comprehensive health care. It must be able to provide the following components of care to each individual as needed: health maintenance, primary care, specialty care, restorative care, and health-related custodial care. Comprehensive health care must be developed as rapidly as possible.

6. The system must be oriented to the maintenance of personal good health and to the prevention of illness rather than being primarily oriented to the treatment of illness after it becomes acute.

   The system must include financial incentives for keeping people well and, if they are ill, for making them well as soon as possible.

7. The system must include financial incentives for encouraging utilization of ambulatory facilities, extended care and nursing home facilities, and home care programs, rather than reliance predominantly on hospitalization.

8. The system must support only those providers that meet standards of effectiveness, quality, and efficiency.

   Providers rendering good quality care in the most economic manner must be continued and developed, providers not providing such care must be assisted to do so; and providers unwilling or incapable of providing such care must not be supported.

   Measurements of the quality of care should be incorporated in the system.

9. The system must, in order to maximize the potential of health resources, encourage innovation and preserve the benefits of alternative choice through a multiplicity of health care providers with varied types of ownership and organizational forms. The predominant concern and mission of all health care institutions and providers must be the public interest regardless of ownership.

10. The system must be designed so that from the outset it provides care for persons suffering from alcoholism, drug abuse, and acute mental illness.

    The system must also be designed so that long-term mental health care, nonhealth-related custodial care, and institutional care provided by all federal, state, and local governmental hospital systems will be integrated into the total system within a reasonable time.

    Programs to resolve sociological and environmental problems that affect the health of individuals must be coordinated and integrated with the system for the delivery of health care.

The failure to resolve acute sociological and environmental problems adds to the cost and amount of necessary health care of individuals. It must be realized that the pace at which these problems are addressed and solved affects directly the organizational burdens and total effectiveness of the health care system.

To accomplish the goals, the existing system for the delivery of health services must be substantially restructured, including both the methods of delivering and financing health services. Priority should be given to the accomplishment of these goals, and the hard choices made of where scarce fiscal, organizational, and manpower resources should be allocated. Attainment of the goal of comprehensive care for all people will require significant expansion of the system's resources.

Part II

THE HEALTH CARE CORPORATION

The Health Care Corporation would synthesize management, physicians, personnel, and facilities into a corporate structure with the capacity and responsibility to deliver comprehensive health care to the community, either directly through its own facilities and services or by contract with other health care providers.

Health Care Corporations would have specific responsibility for quality and effective delivery of care by all of its providers—including those with whom it would contract—physicians, dentists, other health professionals, and health care institutions.

A sufficient number of Health Care Corporations would be established to make available comprehensive health services to meet the needs of every geographic area and of all of the population, spanning geographic and political boundaries where necessary to assure that all persons have access to at least one Health Care Corporation.

Each Health Care Corporation would have a primary geographic assignment established by the State Health Commission. Several such Corporations might have the same geographic assignment and therefore coexist in a city or area and serve population groups beyond political boundaries. The coexistence of Health Care Corporations in one geographic area would depend upon their capacities to coordinate needed services effectively.

The Health Care Corporation would be a new corporate organization. It could be established in a variety of ways, depending upon community need, resources, and precedent. Its sponsorship could be local, or it might be broadly based.

A Health Care Corporation would be a private or governmental not-for-profit corporation organized to furnish services (through its own resources or through affiliation with other providers, not-for-profit or for-profit) to registrants, and to engage in education, research, and other activities related to the furnishing of personal health services.

Many types of organizations could participate with health care providers in the formation of a Health Care Corporation, including health-oriented educational and social organizations, governmental and private organizations, and organizations of health professionals, such as groups of physicians. A Health Care Corporation also could be a consortium, representing a cross section of provider organizations in the community.

However organized, the governing boards of Health Care Corporations should include representation of community, consumer registrants, provider administration, and physicians. In addition to consumer registrant and community representation through the governing boards, each Corporation should guarantee meaningful opportunities for all its registrants to express their reactions to the quality, cost, convenience, and accessibility of services.

The Health Care Corporation would be a provider of health services, with its primary responsibility the provision of health services for its registrants through programs to assure the public:

a) good quality health care monitored through peer and utilization review;

b) accessibility, continuity and availability of preventive, emergency, ambulatory, restorative, inpatient, home care, and health education in a continuum so as to economically provide opportunities for prevention of illness, the maintenance of health, and the most appropriate level of care as needed; and,

c) fiscal responsibility and accountability and full cooperation with areawide planning.

Within its geographic area the Health Care Corporation would have to demonstrate its potential to provide care for all who would voluntarily register during regular periods of open registration and agree to maintain their registration for a fixed period.

It would be the responsibility of the Health Care Corporation to encourage the registration of nonregistered individuals including those assigned by the State Health Commission to the Corporation for recruitment. After a reasonable period, the Corporation, within its capacity to provide comprehensive health services, would be allowed to meet the requests for registration made by individuals not assigned to it or who reside outside of its geographic area, as well as recruit such persons.

Registrants would be free to register with the Health Care Corporation of his choice if there were two or more Corporations in his community, or register with a Corporation in another community or area following the open registration period. Wherever economically feasible given existing or anticipated resources, opportunities for registrants to choose among Health Care Corporations should be encouraged.

Physician participation is fundamental to the Health Care Corporation. Therefore, the Health Care Corporation must:

(1) implement the principle that medical judgments related to health care must be made by or under the supervision of physicians;

(2) assure that the physician's responsibilities and professional relations are defined in accordance with rules and regulations adopted by the Health Care Corporation and its component institutions;

(3) assure that judgments pertaining to the practice privileges of physicians should be made after peer review of their training, experience, and professional competence; and,

(4) afford the opportunity for all physicians, within the limits and capacity of the Health Care Corporation, to affiliate with a Health Care Corporation and provide incentives to attract physicians to practice within them.

Physicians practicing within the Health Care Corporation should be required to participate in management by serving on committees for budget, planning, utilization, and patient care. Based upon their management qualifications, physicians should have the same upward mobility in the management structure of the Health Care Corporation as professional administrative personnel.

Health Care Corporations should develop policies and programs designed to encourage supervisory and professional personnel to participate in management decision-making and review processes. Based upon their management qualifications, these personnel should have equal opportunity for advancement in the management structure of the Corporation.

Every individual shares a responsibility to protect his own health, and proper discharge of the responsibility will reduce the incidence of illness, disease, and injury. In order to encourage individuals to take care of themselves to the maximum extent possible, programs of education to teach people how to exercise this responsibility must be developed, conducted, evaluated, and maintained.

The Health Care Corporation would be responsible in behalf of its registrants for participating in communitywide educational activities sponsored by voluntary and governmental agencies and for providing adequate information services concerning the availability and use of health services. It would have a responsibility for actively encouraging the responsible use of services by its registrants.

The Health Care Corporation must maintain peer review mechanisms as part of the overall program of quality assurance for services of the Health Care Corporation.

The Health Care Corporation and its component institutions should establish a program to review and validate the qualifications of personnel.

Health Care Corporations should be responsible for:

(1) identifying and setting performance standards, in conjunction with its component institutions, for health care personnel;

(2) assisting the educational system in the setting of educational standards for health care personnel;

(3) providing adequate clinical opportunities for the education and training of health personnel;

(4) developing effective means for measuring the quality, use, and economic delivery of each of the five components of comprehensive health care;

(5) through such measurements set priorities of services, taking into consideration, among other factors, the age, occupation,

mobility, and size of the population served; differing patterns in the use of each health service, and the adequacy and availability of these services; and,

(6) conducting research in the delivery of health care services, including the organization of services, to evaluate and then utilize patterns of service organization based on their effectiveness, cost and quality.

To use the nation's health manpower resources more effectively, Health Care Corporations should:

(1) encourage and support the development of health care personnel with skills to augment those of physicians in the diagnosis and treatment of illness;

(2) encourage and support programs to assist members of minority groups to become health professionals;

(3) develop and maintain policies and programs designed to promote career mobility and advancement;

(4) utilize acceptable substitutions of capital resources for health manpower; and,

(5) identify and implement acceptable alternatives to present concepts regarding patterns of distribution and use of health manpower.

A program for providing the public with competent health manpower resources in sufficient number should be coordinated by the National Health Board and the State Health Commissions and Health Care Corporations. The principal objectives of this program should be:

(1) identification of health service manpower requirements for given geographic areas;

(2) establishment of a national program to coordinate and supervise the collection of uniform health services and manpower data;

(3) establishment of study centers, including universities, health planning agencies, and Health Care Corporations, to conduct manpower planning and demonstration projects; and,

(4) establishment, evaluation, and promotion of cooperative arrangements within and among educational institutions and agencies for basic and continuing education of health service personnel.

National standards for the measurement of competency of professional and technical health personnel should be developed and/or improved to verify professional and technical education or training, with specialty training for physicians, nurses, and others to be certified by specialty boards or bodies.

Alternatives to existing licensure provisions should be identified, demonstrated, and evaluated and they should be adopted if they provide for improved delivery of health care services.

Basic educational preparation for health personnel should increasingly become a responsibility of the nation's secondary schools, institutes, colleges, and universities. Programs for the continued training and education of health personnel should increasingly become a shared responsibility of the nation's educational institutions and health care providers.

The educational system, with the support of health providers, should be responsible for:

(1) assuring an adequate number of skilled teachers for basic and continuing education programs;

(2) developing a knowledge of and sensitivity for the special problems, needs, and value systems of various ethnic and minority peoples; and,

(3) preparing health personnel to perform more effectively in the provision of services directed to the prevention of injury and disease.

Society must assure the availability of adequate funds for the establishment and maintenance of education and training programs for health manpower. Private funding resources should supplement the basic governmental investment in education and training which is conducted under the auspices of educational institutions and Health Care Corporations.

Part III

THE ROLE OF GOVERNMENT

Government's ultimate role would be to assure the fulfillment of the basic principle that health care is an inherent right of all the people of the United States.

Federal legislation should establish a National Health Board, create a uniform benefit package and state the scope, standards of quality, and comprehensiveness of health services. The legislation must also require state legislatures to enact, by a specified date, laws establishing State Health Commissions, newly constituted and independent agencies, to assure that the federal regulations were properly met.

The federal legislation and the regulations developed by the National Health Board should specify in sufficient detail the responsibilities and administrative structure of the State Health Commission to permit a reasonably uniform operation of the regulatory processes throughout the United States.

Federal legislation should include provisions for funds to support the operation of the State Health Commissions. The legislation should also include provision for funds to support the costs of organization, start-up, and initial operation of Health Care Corporations.

Additional federal legislation would be needed to help overcome legal and other barriers and impediments to the formation of Health Care Corporations within the states and spanning state, territorial, and district boundaries. A principal objective would be to permit the inclusion of physicians in such corporate organizations; another would be the removal of barriers to the sharing of services and facilities by health care institutions.

The National Health Board would be the nation's primary agency responsible for the continuing assessment of the effectiveness of the delivery of health services. It would be an independent agency composed of five to seven qualified, full-time, well-compensated commissioners appointed by the President to serve for staggered terms of relatively long tenure, for example, six years. The Board would be supported by a qualified staff.

In fulfilling its responsibilities, the National Health Board would:

(1) review the activities of State Health Commissions to assure their enforcement of regulations adopted by the National Health Board;

(2) actuarially determine the revenue requirements for health benefits that are tax-supported;

(3) administer the trust fund for specified health care benefits;

(4) contract with prepayment plans and health insurance companies for the purchase of health care benefits financed through federal funds;

(5) coordinate at the national level the activities of voluntary organizations and governmental agencies with respect to their conduct of approval, accreditation, or certification programs;

(6) maintain liaison with all federal agencies concerned with health-related programs; and,

(7) periodically assess the progress toward developing comprehensive health care, report to the President and Congress on the phasing-in process, and serve in an advisory capacity for legislative amendment.

The State Health Commission would be the agency responsible for seeing that Health Care Corporations conformed to the regulations of the National Health Board. The State Health Commission would consist of three or five qualified, full-time, well-compensated commissioners appointed by the governor to serve for staggered terms of relatively long tenure, for example, six years. The State Health Commission would be supported by a qualified staff:

The State Health Commission would evaluate the structure of Health Care Corporations to assure the adequacy and quality of their services and to determine their capacity to deliver comprehensive health care; authorize their operation; and approve the rates charged for their services.

The State Health Commission, however, would have no responsibility for the internal operations of Health Care Corporations, leaving these to the governing board of each Corporation.

The State Health Commission would:

(1) prescribe conditions, consistent with the federal regulations, for establishing the geographic area to be served by each Health Care Corporation, including in the process consideration of the total population of the state, its distribution, local governmental structures, transportation facilities, existing institutions, and patterns of social organization, as well as existing resources for the delivery of health care;

(2) define the population group to be served by each Health Care Corporation;

(3) provide for the formation of Health Care Corporations for the entire state of compliance with the date specified by the National Health Board and then require existing Health Care Corporations to serve areas lacking such Corporations, authorize the establishment of new Health Care Corporations, or replace existing Corporations which fail to perform adequately;

(4) join cooperatively with the Commissions of neighboring states in approving the establishment of Health Care Corporations that span state boundaries;

(5) assure that policies offered by prepayment plans and health insurance companies operating within the state meet the uniform benefit requirements established pursuant to federal legislation;

(6) regulate the premium structures of prepayment plans and health insurance companies;

(7) assure that Health Care Corporations comply with the regulations for quality and adequacy of service established pursuant to federal legislation and that health care providers

not participating in Health Care Corporations comply with these regulations. State Health Commissions would utilize existing voluntary organizations and governmental agencies in the approval, certification, and accreditation processes;

(8) assure that essential planning functions would be carried out to coordinate activities among Health Care Corporations;

(9) issue certificates of need for the facilities and services of Health Care Corporations and/or their component institutions (the state should also require other institutional providers, not affiliated with Health Care Corporations, to obtain certification of need for facilities and services);

(10) function as the administrative agency for government aid and loan programs, as for example, the Hill-Burton program;

(11) assure that each Health Care Corporation, through its peer review mechanisms, fulfills its responsibility for auditing the quality of care and the utilization of services;

(12) function as a health data-gathering and reporting center for the state; establish requirements for the collection of data on fiscal operations of health services, utilization of services and other health-related data of Health Care Corporations and prepayment plans and private health insurance companies; and,

(13) establish appropriate mechanisms for appeals and review of disagreements in those areas for which it would have responsibility for the regulation of Health Care Corporations. All of its proceedings must be conducted within the usual requirements of legal due process.

The procedure of determination of eligibility of the poor and the near-poor should be established by federal regulations and administered by the appropriate state agency.

Part IV

FINANCING HEALTH CARE SERVICES

A coordinated program for financing the nation's health care should be established through federal legislation. The principal objectives of this financing program should be:

1. the achievement of a more equitable sharing of the cost of health care among all persons recognizing differences in family income; a method of sharing costs which will remove hardships resulting from cost of illness for all income groups and eliminate for lower income groups the financial barriers to the acquisition of good health care, and,
2. the development of more effective means of allocation and more efficient use of resources in the delivery of health care by accomplishing an integrated health delivery system through inducements to consumers, insurers, providers, and government to coordinate the delivery of comprehensive health services.

To accomplish the dual objective of equity and effectiveness, a coordinated financing program established at the federal level should recognize the following principles:

1. Multiple sources of financing should be utilized, for example, general federal revenues, federal taxes collected through the Social Security mechanisms, and payments by employees and their employers through prepayment plans and private health insurance companies. A basic principle is that every person, if able, contributes.
2. Nationwide standards for a specific package of health insurance benefits should be established. This package should:
    a) be available to all people;
    b) provide comprehensive health care, including health maintenance and catastrophic illness benefits, within the limitations of available resources; and,

c) include in the benefit structure, or have associated with it, control mechanisms to regulate the use of services.

3. The role of federal government in financing comprehensive health care should be directed toward:

   a) purchasing through prepayment plans and private health insurance companies health insurance benefits in whole for the poor and the aged, and in part for the near-poor;

   b) encouraging through federal subsidies and incentives all those with sufficient resources to purchase a package of health insurance benefits meeting nationwide standards directly from prepayment plans and private health insurance companies; and,

   c) encouraging major innovative changes in the health delivery system through the federal subsidies and incentives for selected health insurance benefits and in the design of nationwide standards for the specific package of benefits.

4. The federal government should finance health insurance benefits for the poor and near-poor out of general federal revenues and finance other necessary government purchases of health insurance benefits out of a tax collected through the Social Security mechanism.

5. A separate and specifically designated fund should be established for all federal monies collected for health insurance benefits regardless of the tax source.

6. All payments to providers of health services specified in the federally established health insurance benefits should be based upon prospectively determined rates and should be limited to Health Care Corporations approved in accordance with regulations for quality and adequacy of service established pursuant to federal legislation.

   Payments to institutions should be in accordance with the principles expressed in the *Statement on the Financial Requirements of Health Care Institutions and Services.*

   Physicians would have the choice of being compensated by various methods of payment, such as fee for service, capitation, salary, salary plus bonus, or combinations of those.

7. The methods of paying all providers should:
   a) meet the full financial requirements for the delivery of comprehensive health care;
   b) give incentives for the use of that component of care which is most appropriate under the circumstances to provide the care economically, make the most effective and efficient use of the health resources, and keep people well; and,
   c) include broad scale experimentation with alternative methods of payment, including capitation.

8. Prepayment plans and private health insurance companies should offer and encourage individuals with sufficient resources to purchase supplemental benefit coverage beyond the specific package of benefits meeting the nationwide standards.

Mr. ROSTENKOWSKI. Thank you, Mr. McMahon.

In reading H.R. 1 it seems that there are four kinds of costs which would be involved in the bill when it would be fully in effect: (1) General revenue costs to the Federal Government; (2) costs to the employers; (3) payroll costs; and (4) tax expenditures resulting from lower tax receipts in the form of employer contributions to health insurance not taxable to employees.

Have you prepared estimates on what these cost elements are or what they would be?

Mr. MCMAHON. Mr. Chairman, we did at one point and we will submit our estimates of those. Part of the problem is that from year to year those costs vary.

[The information follows:]

The total expenditure of H.R. 1 for FY 1975 is estimated at $85.5 billion. The breakdown by type of plan is:

	Billions
Employee plan	$44.0
Federal plan for the aged, poor and medically indigent	35.0
Other enrollees in HCC's	2.0
Federal subsidies	3.0
Residual medicaid	4.5
Total	85.5

These figures are based on estimates of national health expenditures developed by ORS, SSA for FY 1973. The 1975 figures were estimated by SSA in 1974 using the 1973 data as a base to projecting them to FY 1975.

Mr. MCMAHON. Let me say this: As we see it, the payroll tax revenues in the social security mechanism would not change greatly. They are in place and in our proposal for the retention of medicare there would be no great change in their amount.

On the general revenues, there would be a substantial increase because we believe that the problems of Federal-State programs for the poor and the near-poor have proven that they have got substantial problems.

The unevenness, Mr. Chairman, of medicaid programs from State to State presents a very real problem.

Thus, we are suggesting really what amounts to a federalization of medicaid and that would increase the responsibiilty of the Federal Government.

As far as employer and employee programs go, many of the programs in the country at the present time—it is our estimate that some 70 to 80 percent of present employment-related health insurance programs would meet the test of comprehensive health benefits and, thus, would involve no substantial change.

It is quite true that in some cases there would have to be additional—an increase in—benefits in some of the inadequate employment-related programs and that increase would have some effect, of course, on Federal tax revenues. But I point out, Mr. Chairman, that that is a better alternative as we see it than going in other ways because at least it builds and does not get rid of the present dollars that are flowing voluntarily. In some other areas, specifically in relation to the suggestions we made for coverage to the unemployed, there could be some slight increase in health insurance premiums particularly in periods of unemployment because our recommendation that employed people be covered by their employment-related coverage through periods of unemployment would add a benefit that does not exist at the present time. But I would point out, Mr. Chairman, that that is a better alternative again than many of the others which would tend to rely on governmental funds or tax funds for that purpose.

We think that our suggestions would have far less effect then and yet accomplish the same goals as would Federal tax fund supported programs.

Mr. Rostenkowski. Do you believe, Mr. McMahon, that this subcommittee should write a national health insurance bill in this Congress even though it may not be made effective for a couple of years and then staged in such as H.R. 1?

Mr. McMahon. Yes, sir, we certainly do for a variety of reasons.

We think that some of the decisions on national health insurance need to be made now before decisions in other parts of the governmental process. For example, now we have to deal with some of the problems of the new National Health Planning and Resources Development Act. Before other mechanisms are put in place, whether it be health manpower, the development of additional health facilities, or other matters, even the amendments to medicare and medicaid are drastic amendments, some of which have been suggested to this committee, we think it would be very appropriate to provide the national health insurance framework and then move in that framework. Then you would have, Mr. Chairman, established the policies within which other segments of health care regulation or health care manpower and facilities could take place.

Mr. Rostenkowski. One more question: Would you urge us to develop a prospective reimbursement program for medicare before national health insurance becomes effective?

Mr. McMahon. Mr. Chairman, there are real problems with that. As I mentioned in the course of our oral statement, we have addressed ourselves to some of those. We looked at prospective ratemaking in the context of a system in which payment would be made for all patients. At the present time, health care institutional providers face a very real problem because prospective rates are set so often without consideration of the fact that a number of patients will not be able to pay their bills or will not be able to pay all of their bills. Thus, if a prospective rate system is to be put into effect, it must give attention to the fact that there are many individuals at the present time who fall between the cracks and, thus, adequate preparation or adequate provision would have to be made for that aspect of it.

We do think that it would be very important to continue as this committee has in the past, encouraging the development of experimental programs in prospective rates because there are a lot of problems that we—because of lack of experience—have not yet dealt with.

For example, there is the problem I mentioned of the bad debts and the uncollectibles and the charity allowances.

There are problems, Mr. Chairman, that any prospective rate mechanism is going to have to be based on certain assumptions. Those of occupancy, certain assumptions of the mixture of patients from the sick, to the very sick, to the critically ill, because each takes a different kind of care and the number of people needed to take care of the patient vary markedly with the nature of his illness.

And there are other assumptions necessary to set a rate of payment. We don't know how all of these things will fit together, Mr. Chairman, because if underestimations of occupancy are made for example, the institutional provider may have revenues far beyond expectations.

Conversely, if other estimations are made or something happens in the environment that causes a reduction in occupancy, the health care provider with rates based on assumptions of greater occupancy may not have adequate revenues to keep the doors open. Despite these concerns, we recommend in our testimony of September 19 before your committee the establishment of a dual system of reimbursement for hospital services under medicare. The first part of the dual system is a State-administered option under Federal guidelines for phasing in prospective institutional reimbursement which would apply to all payers in the State not merely medicare, provide for meeting all institutional financial requirements, and permit a variety of methods to be utilized for such prospective reimbursement. The second method, to be used where a State does not provide an option such as has been previously described, would utilize a medicare classification screen to replace present cost containment provisions. Institutions whose costs were within this screening level would be presumed to have reasonable costs and those that exceed the screening level would be required to justify their higher costs. If a hospital could not justify those higher costs, it would be required to take corrective action in a reasonable time or be penalized by the disallowance of costs which exceed their justified level.

We think some other ratesetting problems are important, too. We have testified before this subcommittee on some of the problems with the present classification system used to establish reimbursement ceilings under medicare and medicaid. Certainly, we couldn't live under prospective rates set using some of the ways that the Department of Health, Education, and Welfare has moved to implement some of the prior legislation enacted by the Congress.

Mr. ROSTENKOWSKI. Mr. Duncan will inquire.

Mr. DUNCAN. Thank you, Mr. Chairman. I would like to again welcome you, Mr. McMahon, and Dr. Gehrig, back to the subcommittee and we always look forward to a fine presentation and the statement and the colloquy that usually follows has been most helpful to us.

We have had prior testimony that suggested that it is very important to shift resources to encourage more outpatient and ambulatory care in connection with the national health insurance. The testimony was to the effect that it would be making health care more cost-effective, would you agree?

Mr. McMAHON. Mr. Chairman, I was just reading some of our most recent statistics last night in this area and if you allow me, let me elaborate just a little rather than giving a brief answer.

During the economic stabilization program because of the strictures imposed on health care institutions, the rate of growth of outpatient activities slowed markedly. It has now picked up again. Part of the reason that hospitals have difficulty financing growth in their ambulatory services, is that we don't collect as much of what is billed for the rendition of outpatient services though it provides a very real service, as we do on the inpatient side because of the inadequacy of outpatient coverage of many health insurance benefit programs.

We think that can be improved in any national health insurance program because obviously outpatient ambulatory services in whatever setting should be covered in order to encourage the service at the lowest point consistent with quality of care and with cost effectiveness.

I would say this, however, that while I took actions in other parts of my career to encourage outpatient activity and while I know that you do it with a hope over the long term that it will bring about more cost effectiveness, I think what will happen in the short run, and it certainly happened to me in a carrier role, Mr. Duncan, when I insisted on the inclusion of outpatient benefits in every health contract, we found that the costs increased markedly because while there was a marked increase in outpatient coverage, what it seemed to be doing was to discover additional cases that needed inpatient care.

What you have to do, Mr. Duncan—because I don't think you can prove that it is right—is to accept the fact as an article of faith that outpatient and ambulatory coverage in many cases are more cost effective. Whether the 1-day surgery, whether it is the night and weekend outpatient activity when a doctor isn't available, or whether it is a preadmission testing item, you do it as an article of faith, recognizing that over the long term you probably will reduce the number of inpatient beds specifically that one will need.

But to assume that an increase in outpatient or ambulatory coverage in the short run will reduce the cost of the care is not only unrealistic, it isn't going to happen.

Mr. DUNCAN. Recently there appears to be a good deal of militancy by the interns and residents in their relationship with hospital staff and they seem to be demanding more input as to what type of care should be given to patients. Do you believe that Congress should be concerned with problems such as these in determining a national health insurance program?

Mr. MCMAHON. No, sir; I do not. I would hope that——

Mr. DUNCAN. You can handle that yourself?

Mr. MCMAHON. We are hoping we will. I think it does suggest a need for a higher level of discussions, let's say, between the hospital administrations and the medical staffs, people responsible for the training programs and the residents and interns. But at the present time we believe that in a variety of ways that we can deal with this matter better without legislation.

Mr. DUNCAN. Another subject and I will be through, and this is related to these hearings. You were here, you and Dr. Gehrig, several months ago when we were discussing extension of hospital benefits for the temporarily unemployed. At that time you were unable to really determine what impact unemployment might have, and the number of people who would come to the hospital without hospital insurance. What is your view on that subject now?

Mr. MCMAHON. What did happen?

Mr. DUNCAN. Yes, sir.

Mr. MCMAHON. Apparently, Mr. Duncan, there has been particularly in the last 6 months some slight decline in the number of admissions. But we are talking about 1 percent.

We are a little less confused than we were some months ago because all we had to go on then was what had happened in previous recessions when there was not the great extent of health insurance coverage, but it seems to have followed very much the same patterns as before. Health care is a necessity and when people become sick, they go to the hospital and worry about the consequences later on.

We have not seen—well, I guess up through the month of August or September—we have not seen any marked increase in hospital accounts receivable. We have not seen any substantial reduction in the level of activity.

So I think a couple of things, Mr. Chairman: It tends to support our position that it is best to build on what we have now because it seems very clear that, for example, things worked well in steel and auto and other areas of unemployment where the health insurance coverage did follow for periods of time into the unemployment period and I think it is also fair to say that the States apparently have picked up some of the unemployment problem through medicaid programs.

I think, Mr. Duncan, while it probably will take sometime after the end of recession to go back and look at exactly what did happen in all of these areas, it seems to be a matter that in the overall the problem is quite slight. But, of course, it is not slight with respect to the individual whose health insurance has lapsed and who has lost his job at the same time.

Mr. DUNCAN. I agree.

Mr. MCMAHON. I think it is fair to say when we look at statistics, 1 percent doesn't seem to be very much, but 1 percent of 200 million people is 2 million people, and when you look at that number, you see it in a different dimension. It has not presented a great problem to the hospitals as such nor has it made much change except as I said in the decline of admissions.

Mr. DUNCAN. My time is up and I thank you very much.

Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Corman will inquire.

Mr. CORMAN. Thank you, Mr. Chairman.

I always enjoy listening to you and sometimes even have a chance to debate, though that is not the occasion this morning.

Let us focus a minute on your statement that we ought to retain private insurance, that competition there somehow benefits people.

Let us lay aside the program administration because I think there may have been some wisdom in the GAO report, although Social Security did rebut it pretty vigorously. But whatever program you have, somebody has to administer it. In terms of underwriting, what can insurance companies do that is of any benefit to cost control if they cannot regulate the provider and what he charges?

Mr. MCMAHON. Mr. Corman, by giving careful attention to the benefit package, for example——

Mr. CORMAN. Let us look at that. The benefit package is what I am buying. I can buy a little bit for a little bit of money or a whole lot for a whole lot of money, but what does that have to do with what health care costs me at the other end of the line?

Mr. MCMAHON. Mr. Corman, if you start off mandating and financing through governmental sources a specific benefit package, you don't provide the flexibility I was suggesting that competing carriers can do. Go back to part of the response that I made to Mr. Duncan. I was, as some of the members of the committee may know—I have some experience in this. I was for 7 years involved in Blue Cross and Blue Shield in North Carolina. I understood then that there is a competition in the way you put things together.

If you keep this in the private sector, there is an opportunity for experimentation in the tradeoffs of certain kinds of benefits in the encouragement of outpatient activities. Certainly I don't think we have come to a point where there is enough satisfaction with the health delivery system and health financing system in this country to solidify it in a governmental program.

I think that a private carrier based in and close to the people being covered sees things that are not discernible beyond Washington.

For example, some companies have substantial in-house medical programs for their employees. Now there is no reason to pay for that in a benefit package if the company is going to do that on its own. So that when I talk about tailoring benefit packages, I am saying you can do it closer to the scene than you can if you are writing one national program that assumes that everybody has the same kind of employer, and that everybody has the same kind of setting.

There is another activity involved in all of this. By being close to the scene, by having the advantages, joys, and disappointments of competition, you also have a number of people that are then trying to figure out how they can increase their share of the market. Sometimes this did, as it did with me—it encourages close to the scene the deevlopment of health maintenance organizations. In our system we call it "health care corporations."

But I would say to you, Mr. Corman, these are hard to develop because it is hard all of a sudden to put in place both the delivery mechanism and the people to be served. You have to work very closely in this and hopefully we will see ways of doing this with the new health systems agencies in the planning process. But it takes local competition among private enterprise-oriented businesses, to make sure that as they seek their share of the market, they are finding ways to do things less expensively. That is a much better way, as we see it, than a uniform national program centrally financed.

Mr. Corman. Yes, sir; but the insurance company is not in the business of delivering health care.

Blue Cross is a slightly different operation but generally insurance underwriters are not delivering care. They are not controlling prices. They are saying for a certain number of dollars we will protect you from a certain kind of risk, be it automobile accidents, malpractice, and all kinds of adversities.

But when that company has no control over what health services cost, then all they can do is increase premiums as those outside costs go up. Now why would health insurance be any different from automobile insurance or medical malpractice insurance unless you give the insurance company some mechanism for controlling the cost of what it is they are insuring us against?

Mr. McMahon. Mr. Corman, I competed with some of those companies and they were certainly more than passthrough activities. They were interested in the cost of care, particularly when they began to see just as we did under Blue Cross and Blue Shield, when they began to see an individual institution or institutions utilizing—or costs of care that seem to be out of line with the others.

In support of the planning process they focused on what was happening locally. They were using negotiation and comprehensive health planning agencies to raise questions so that they are not and Blue Cross and Blue Shield is not, Mr. Corman, the kind of passive activity that you suggested. One again competition comes into this.

Their interests in health coverage, as I can tell you from competing with them, was based on the hope that by serving a company well in the health insurance area, they would add life insurance and disability payments and other kinds, retirement programs and so on.

So they were by no means passive and even absent regulation they were looking for ways to encourage modifications of behavior, both on the provider and insured person's side, that I suggest to you as I did in earlier ways, because they are close to the people being affected. It will be far more effective than anything run from a central government.

Mr. Corman. What do we do about people who are not economically poverty stricken, if the government does not pay their premiums? As you know, there are many such people.

Mr. McMahon. Right.

Mr. Corman. They are not wealthy and when they look over how they will spend their dollars and health insurance is expensive, they decide not to buy it.

Mr. McMahon. The small employers, marginal people, farmers and so on.

Mr. Corman. Yes, lots of folks. You know, they do not work in a place where they are covered or they may go in and out of the labor market. Or if we are going to let coverage be voluntary, as employees, they may opt out of it even then.

Mr. McMahon. They may indeed.

Mr. Corman. What do you do with them when they get sick?

Mr. McMahon. The first thing we do is through pooling on a State basis. There is every evidence that there will be carriers interested in participating in the pools that we can provide by spreading the risk over a number of people.

Mr. Corman. But that is a second step and I am still at the first.

How do you decide not to get in the pool? I am healthy and I think I will never get sick and make $42,000 a year and I can hardly afford health insurance for my family, and that is almost true. I have not seen the new premium bill, from Aetna. Assume I look over what I want to spend my money for. When I get sick, I want to get in the pool real quick, but I can't afford it.

I do not have any money left because I am sick and here I am. How does my bill get paid?

Mr. McMahon. There are two ways to go, Mr. Chairman. The first is to require as part of the plan—just as you can impose taxes, you can impose a requirement—that insurance be obtained. The second is you can encourage insurance through some kind of subsidization as well.

We think it is better to require it. We think it is better because that is the alternative to taxation. Taxation is mandatory, this kind of coverage would be mandatory, and from the provider's side as well as from the side of the individual we think that that is a better way to go.

It is a practical matter, Mr. Corman, and as you know, they are going to be covered anyhow and the question is who pays when that husband, or wife, or child, or parent, becomes sick? They are going to go to the hospital. Therefore, the risk-sharing mechanism is either indirectly through the establishment of rates that will take care of these people or it is through their own contribution.

We think that requiring insurance is a much better way to go because then they have the coverage when it is needed and the costs are not passed on to someone else. Moreover, instead of them being in a position to wait until they are sick enough to require the greatest expense, you require them to have coverage that will enable them to seek care at the earliest moment.

You combine that with good health education and we can get them into the system early on.

Mr. CORMAN. I am sure my 5 minutes is up, but we agree on one thing. Whatever we do we will have to make it compulsory for everybody.

Mr. McMAHON. Thank you.

Mr. ROSTENKOWSKI. Mr. Burleson?

Mr. BURLESON. No questions.

Mr. ROSTENKOWSKI. Mrs. Keys?

Mrs. KEYS. I am sorry I missed the testimony of you two gentleman this morning. I will read your testimony carefully. You have always provided me with a great deal of information.

I looked through the policy statement and do certainly applaud your belief in universal coverage. I listened to Mr. Corman's questions with interest and find it a bit hard to equate some of our answers with some of the things you have called for in your policy statement, but perhaps I will have a chance to pursue that with you another time.

Mr. McMAHON. Mrs. Keys, that is a very complex statement. H.R. 1 is a very complex bill, but I guess it was Mr. Mencken, who said the first time that for any major problem there is always a solution that is simple and direct and wrong. We think that complex problems take complex solutions.

The other thing is that in the passage of 4 years now, just as Mr. Ullman has modified his bill each time, we learn things in the process.

What I said this morning, I am consistent, or it is consistent with our original position though it may have been slightly modified. But clearly as the discussion goes on, I think you all will find in the course of your deliberations you will explore areas and pool ideas and experiences so that we can come out with the best possible answer to some of these complex problems.

Mrs. KEYS. One thing I know is that health, ill health or otherwise, is not something one plans. Birth defects, different problems that still have been totally unanswered by our present system are totally unplanned.

I think that health care must be available as a right of every citizen in this country today. I believe you gentlemen do, too. We still have a long way to go to influence and put together the kind of system that will make that possible.

Mr. McMAHON. Yes.

Another reason for going slow, Mrs. Keys, is because we know we cannot wave a magic wand and do everything the day after tomorrow. It is as the Chairman suggested in one of his questions, a matter that we need to begin on, but to recognize that the full implementation of adequate services for everyone at a price they can afford can take a long time for all of you, all of us working together in a sound and conceptual framework.

Mrs. KEYS. I think it is a matter we should have made a larger beginning on 20 years ago, and it is an idea whose time has certainly come.

Mr. McMAHON. Mrs. Keys, maybe the reason that we didn't make that start was that we had many of the uncertainties we do today, but that the Members of the Congress also realized that tremendous strides and progress were being made in the voluntary sector. If you went back 20 years and said, I suppose, what percentage of the people by 1975 would have catastrophic coverage in their regular insurance programs, nobody would have thought it was going to be as high as 70 percent. We hardly knew about major medical and catastrophic coverage 20 years ago.

Moreover, if someone had told the hospital field that by 1975 they were going to be taking care of three times as many outpatients as they were inpatients, they would have found it incomprehensible because few hosiptals had outpatient activities beyond a limited emergency room activity.

So there has been a tremendous amount of progress being made in the voluntary sector with some of the—under some of the competitive urges and pressures Mr. Corman and I discussed.

Mrs. KEYS. Right. We also have developed some real steps toward the goal within the public sector with PSRO's, utilization review and health planning, and health manpower.

Mr. McMAHON. Right.

Mrs. KEYS. One thing that concerns me still is that we have roughly 50 percent of our insurance policies which deliver only when a person is hospitalized.

The percentage may be a bit higher but I questioned the Blue Cross gentleman who was before us last week and those are things that have not come along fast enough and those are very grave problems in answering the crucial problem of whether or not we are really caring about the health of our citizens. My time is up.

Mr. McMAHON. From what I know of the situation in North Carolina, I believe that would be about what could be said of that State Thank you.

Mr. ROSTENKOWSKI. Thank you, Mr. McMahon.

Mr. Williamson, Mr. Bromberg.

Welcome to the committee gentlemen. If you will identify yourselves and your association, you may then proceed to your testimony.

STATEMENTS OF DAVID G. WILLIAMSON, JR., PRESIDENT, FEDERATION OF AMERICAN HOSPITALS, AND MICHAEL D. BROMBERG, DIRECTOR, NATIONAL OFFICES

Mr. BROMBERG. Thank you. I am Michael Bromberg. With me is David Williamson, president of the federation and vice president of Hospital Corporations of America, which is the world's largest hospital management company, owning and operating 70 hospitals in 15 States and abroad with more than 10,000 beds.

We will divide our testimony, Mr. Chairman, submitting it for the record with your permission in full, and reading excerpts from it.

Mr. ROSTENKOWSKI. Without objection.

Mr. BROMBERG. On behalf of the members of the Federation of American Hospitals, Mr. Chairman, we would like to thank the committee for this opportunity to present the views of our organization on national health insurance.

The Federation of American Hospitals is the national association of investor-owned (proprietary) hospitals, representing approximately 1,100 hospitals with over 105,000 beds. Our member hospitals range from small rural facilities to large urban and suburban comprehensive medical care institutions. Investor-owned hospitals in the United States represent approximately 25 percent of all nongovernment hospitals. In many communities over 300, investor-owned facilities represent the only hospitals serving the population.

Not only do our facilities deliver quality health care, they also pay a substantial amount in taxes, amounting to $115 million in Federal and State income taxes and $39 million in local property taxes last year alone. It would cost more than $6 billion in public funds to replace the beds built by investor-owned hospitals.

Investor-owned hospitals have been founded by local citizens to fulfill urgent community needs, but more significant to the scope of these hearings is the fact that investor-owned hospitals have been able to operate at a rate commensurate and competitive with the rates of other hospitals. This is true even though proprietary facilities pay taxes and are subject to the same requirements for licensing, accreditation, and certification for medicare, medicaid, and various Blue Cross programs as are other hospitals. Not only are our hospitals committed to providing quality health care at a reasonable cost, but we believe the free enterprise sector of the hospital field can make a significant contribution in the development of a more effective and efficient health care delivery system.

We appreciate this opportunity to set forth those specific goals which our association believes should be established in drafting national health insurance legislation.

After considering a long list of desirable objectives, we would narrow the major goals of a national health insurance plan to the following two:

One. Provide a minimum benefit package of health care insurance to all Americans; and

Two. Provide protection against catastrophic costs of prolonged illness to all Americans.

The state of the Nation's economy is often cited as the major reason this Congress is not expected to pass a comprehensive national health insurance bill. The economic situation and the huge Federal budget deficit also led to the President's moratorium on new domestic spending programs this year.

We would suggest to the subcommittee that the current economic climate is the ideal one in which to consider the issues involved in drafting a national health insurance bill. Fiscal responsibility and the lowest utilization of public sector dollars would be the necessary ingredients of a health insurance program drafted in this period of Federal spending restraint. That kind of health insurance program, while drafted now, could, and we believe should, be phased into being over a number of years further cushioning the economy from the inflationary impact of sudden increases in the demand for health services.

For these reasons we commend you and your subcommittee for scheduling these public hearings and urge you to follow this stage of your consideration with an effort to draft a bill which minimizes public sector spending, payroll tax financing, and government administration, and instead maximizes private sector financing, insurance, and administration.

The general approach supported by the federation is the restructuring of a pluralistic health care delivery system based on pluralistic methods of financing and administration. We are confident that if competition is encouraged within the health delivery system, the consumer of health care will reecive the benefits of a more efficient system. By competition we mean not only competition among providers of health care, but also competition among health delivery organizations, insurers of health care, and financing and administration systems in the health field.

We do not support any program which would place all funds needed to meet the cost of health care in a single entity—whether private or public. For that reason, we oppose the concept of a single Federal trust fund managed and controlled by a Federal agency. Similarly, we believe any national program should address itself to the delivery of care as well as the financing mechanism.

We believe, for example, that the Federal Government should concentrate on the following areas of priority—first, assuring that those persons without the financial means to pay for needed health care have equal access to the health system and, second, that all Americans, regardless of financial means, are protected against the catastrophic or financially burdensome costs of health care. We believe that the private sector, including insurers and providers, can develop an orderly and efficient system for the protection of those working Americans and others who can afford to pay a reasonable price for quality health care that is delivered efficiently and economically. We believe the impetus to imaginatively restructure the delivery system should and will come from the private sector with encouragement by the Government. By maintaining this balance between public and private approaches to the health field, we can assure a dynamic system rather than a stagnant one.

The federation supports the concept that all employers should be required by Federal law to provide basic protection against the costs of health care for their employees. This protection should meet minimum Federal standards.

We believe that a mandated employer-employee health insurance program should be designed in a manner similar to the workmen's compensation laws, with private rather than public financing.

I might add at this point, Mr. Chairman, that employer financing is a common basic element of several national health bills including H.R. 1 sponsored by Chairman Ullman including Congressman Burleson's bill, Congressman Duncan's bill and also the previous CHIP bill.

We support unlimited inpatient care and physicians' services, home health care services of 100 visits per year, and well-child care as some of the major benefits that should be included in any package. In addition, the federation supports the position of equal inpatient coverage for the mentally ill, with expanded outpatient psychiatric benefits. Individuals should not be discriminated against because their illness is not physical. A mental illness can also be every bit as catastrophic as poor physical health—and the two often go hand in hand—and should be covered equally.

We support comprehensive coverage including catastrophic health insurance for all Americans as a part of any national health insurance system. Once the deductible under this major medical type of coverage is met, we believe that all illness-related expenses should be covered, not just those in the basic benefit package. This includes cost of prescription drugs, inpatient and outpatient psychiatric care, dental care, long-term chronic illness care in nursing homes and all other illness-related care. Catastrophic health costs in any form should be covered as soon as the annual family or individual deductible is met.

The financing of the catastrophic health insurance program or the financing of the catastrophic illness component of a comprehensive national health insurance bill should in our view be achieved through a combination of insurance purchased in the private sector and the use of general Federal revenues.

We urge you to reject any proposals to utilize a Federal trust fund based on payroll taxes as the method for financing catastrophic insurance. Such proposals would expand the medicare system to cover the major illness expenses of all Americans and would expand the role of the Social Security Administration as regulator, administrator, and payer for health care. Our experience under medicare for the past 10 years leads us to conclude that any expansion of this approach to health insurance would be highly inflationary and unnecessarily complex and costly to administer.

Since the passage of medicare, health providers have been forced to increase charges to private patients to make up for actual costs incurred but not recognized by medicare. By expanding the medicare administrative mechanism and its retrospective cost reimbursement system, you would be compounding the inflationary impact of medicare caused by increased charges to nongovernment insured patients.

As alternatives to that payroll tax financing and that social security regulation, we urge the subcommittee to consider the following suggestions:

One: Mandated private insurance with employers required to purchase federally qualified catastrophic insurance policies and required to pay a majority of the premium;

Two: An employer-financed catastrophic insurance program for the unemployed through continued coverage under private insurance policies previously purchased by employers. That approach could be patterned after H.R. 5970, the Emergency Health Insurance Act reported favorably by this committee this past April. To deduct the cost of health premiums, employers would have to purchase policies which meet Federal standards.

Three: Tax credits for direct medical expenses which exceed a specified percentage of income. That approach could be coupled with tax rebates for low-income families where catastrophic medical expenses exceed tax liability. Administration of that credit rebate plan would be under jurisdiction of the Internal Revenue Service and would be less costly and far easier to administer than a medicare type program.

Four: General revenue to purchase private catastrophic insurance for nonemployed individuals and the near poor. The Secretary of Labor or the Secretary of HEW could administer this kind of program by negotiating with private insurance companies for group rates based on a pool of beneficiaries. By using general revenues, the tax burden for financing catastrophic benefits would be spread more equitably over the entire population rather than under a payroll tax.

I might add that that system would aid financially troubled cities by removing their medicaid burden. We do not believe there is any single form of health care delivery which can meet the Nation's health needs.

A single form of delivery would destroy the power of the health care consumer to select and shape the system of his choice. For example, while we support experimentation with heal maintenance organizations, we would not recommend that all or even a majority of consumers be forced, directly or indirectly, to enroll as subscribers in such organizations. Hospital based HMO's in particular offer a most promising opportunity for initiation of this method of health delivery, requiring a minimum amount of capital expenditures because of the already existing facilities and resources. The effectiveness of the system can only be measured by the relative strengths or weaknesses of competing systems. A delicate balance must be maintained if the consumer is to have true access and true freedom of choice in selecting the system which serves him best.

Now, Mr. Williamson will address the very important issues of the role of the private insurance companies, hospital reimbursement, and State regulations.

STATEMENT OF DAVID G. WILLIAMSON, JR.

Mr. WILLIAMSON. Mr. Chairman, thank you very much for this opportunity to be here again.

In regard to the role of the carrier, the federation favors an approach in which the carrier acts in the capacity of a private insurance company rather than as a fiscal intermediary. We feel that utilizing carriers in their present role as private insurance companies is the approach most conducive to strengthening competition and providing for the dual administration of the national health insurance program by both the Social Security Administration and insurance companies. There is a great deal of experience and expertise available in the private sector for the administration and design of health plans and it should be utilized. The Secretary of HEW should be authorized to enter into contracts with carriers as administrators of the benefits offered under a system of national health insurance.

The carriers themselves would have to meet Federal requirements before they would be qualified to participate in the program. Such a system creates incentives both for employers and insurance companies. Since private employers would be required to provide basic benefits to their employees, they would have the economic incentive to contract with carriers offering the most attractive programs. On the other hand, the insurance companies would have an incentive to keep the cost of the plans down in order to attract business. Thus, the element of competition, as well as free enterprise, is introduced into a program of national health insurance. Such would not be the case if the Government were to act as the insurer, because competition would be eliminated, as would be the incentives to contain costs.

Some proponents of national health insurance favor carriers as fiscal intermediaries, operating much as they do under the present medicare program. Competition would be eliminated because insurance carriers would cease to be in business for profit. There would be no incentive to keep costs of operation down. When the insurance companies are permitted to function as private commercial enterprises, they would be more likely to "ride herd" on the billions of dollars in claims that will be filed. With prospective payment systems in effect and carriers competing to contract with employers for the basic benefits package, it would be in the carriers' best interest to monitor claims closely to contain costs.

We are also concerned about the provisions in H.R. 21 for the creation of a security board which would have the responsibility of administering the national health insurance program. The federation has strong reservations about the creation of such a superagency with such vast controls. We feel that it could be a mistake to place administrative and regulatory powers in any one organization, when it is possible to rely on the present system of private insurance companies and hospitals and other providers working together under Federal guidelines to administer a national health insurance program.

The federation favors the creation of a separate cabinet-level Department of Health. I will skip that portion because it has been spoken to earlier today.

With respect to hospital payments on page 13 of our statement, the increasing costs of providing hospital services during the past 8 years has brought about a series of arbitrary controls and proposals for Government regulation of hospital rates. The federation has, from its establishment in 1966 called for the adoption of negotiated prospective rates or prospective payment systems as the single-most effective device to curb spiralling hospital costs.

Notwithstanding a number of cost-escalating factors, that we are all familiar with, we believe that the Nation's hospitals can hold the line on inflation given the proper incentives—and I think the word is incentives, for sound innovative management. To do this, we must first rid the system of a prime culprit and that is, retroactive cost reimbursement.

The system of retrospective cost reimbursement has been a major cause of inflation in hospital services because it penalizes efficiency and gives the hospital manager an incentive to increase costs to maximize reimbursement. On the other hand, prospectively determined rates provide incentives for efficiency with economic rewards for those who are able to bring effective management techniques to an institution.

There are many types of systems upon which to base the development of prospective rates. These include negotiated charges, a formula to determine payments, group target rates, and rate review boards with the resulting payment based on per diem, per admission, per capita, per procedure or other units of service.

In order to preserve and encourage a pluralistic health system, we favor the use of multiple prospective payment methods similar to those authorized under H.R. 1. We believe that several prospective rate systems should be developed and that hospitals should have the option of selecting from those approved systems. We commend Chairman Ullman for his leadership in providing for the development of such prospective payment methods to hospitals in his own revised health insurance legislation. We urge modification of those provisions of H.R. 1 to strengthen the role of the Federal Government in establishing guidelines for multiple prospective rate systems and to limit the power of State governments or State commissions in regulating hospital rates.

We recommend that any national health insurance bill reported by this committee contain hospital payment provisions similar to those contained in section 236(5)(a) of H.R. 1 with the following modifications:

One. The prospective payment methods should be negotiated and developed in the private sector by providers, third-party payers. and other interest parties, under Federal rather than State guidelines. The Secretary of HEW should be empowered to disapprove agreed upon systems only upon a finding that the methodology is inconsistent with the Federal criteria. That decision should then be subject to both administrative and judicial review;

Two. The Federal guidelines should encourage competition among similar providers by providing for payment methods under which similar rates are established for all providers in the same classification based on size, scope of service, and geographical area. The system should also assure that rates for an individual institution will not be reduced because of a prior year's efficiency of performance, otherwise a provider will be competing against itself instead of other providers, producing an incentive to increase expenditures; and

Three. Providers should have an annual election from at least three approved payment methods. The election would be made in advance of the provider's fiscal year and there should be flexibility in regulations governing the election.

We wish to commend the chairman of the full committee for providing that the rate of return for investor-owned institutions projected in developing the payment method should be related to total assets rather than equity. The attraction of private risk capital is essential to meet the modernization needs of the hospital industry and to replace substandard, antiquated beds. This will only happen if the basis for return is related to investments of comparable risk, a fact recognized under section 212 of H.R. 1. The return on equity under medicare has certainly proved to be far below any return for investments of comparable risk.

We are confident that the private sector can do the job if given the chance and the motivation. The chairman's proposals for prospective payment methods recognize that the ingenuity of private industry can produce a better health delivery system. We urge the committee to act favorably on this approach.

With respect to State ratesetting, some national health insurance legislation calls for the establishment of State ratesetting commissions to determine health provider charges. We reject the idea that hospitals should be regulated as public utilities. There is a crucial difference between hospitals and public utilities—in most communities there are alternative sources for providing necessary health care, unlike the monopolistic system imposed by utilities. Competition can be infused into the health care delivery system by utilizing equal bargaining power between hospitals and insurance carriers at the local level. This assures responsiveness to local needs.

Insofar as the federation is concerned, there is little to recommend about a State ratesetting system. Such a system would mean yet another layer of bureaucracy over an industry which is already subject to a great deal of control. The expertise necessary to operate this type of control program at the State level would have to be developed from scratch.

Finally, but quite importantly, it appears that national health insurance in any form will be funded primarily on the Federal, not on the State level. Therefore, it seems unreasonable to delegate to the States responsibility for determining appropriate payment for services rendered under a Federal program.

There are many other goals which should be incorporated into a national health insurance bill, such as providing appropriate incentives for cost containment, assuring quality of care delivered, choice of delivery systems, access to health manpower and facilities, administrative simplicity and due process. Those objectives, however, do not necessarily require passage of a national health insurance program to be achieved. That is why we hope that this subcommittee will continue its work on comprehensive medicare reform, especially prospective rate mechanisms. It is in this particular area, Mr. Chairman, that I would disagree with the previous testimony on this very point.

Although the federation does not endorse any specific bill in its entirety, we believe that the August 19, 1974 draft prepared by Ways and Means provides an excellent start in the right direction. With the exception of the provision for a payroll tax to finance the catastrophic illness protection we are in accord with the overall approach of this draft and hope that it will serve as a base for further discussions. We believe that national health insurance legislation can be enacted which is consistent with efforts to hold down Federal expenditures provided the program is phased in and does not require massive Federal spending, but relies on the private sector for administration.

Mr. Chairman, that concludes my testimony and we would be happy to answer any questions.

[The prepared statement follows:]

STATEMENT OF DAVID G. WILLIAMSON, JR., PRESIDENT, AND MICHAEL D. BROMBERG, DIRECTOR, NATIONAL OFFICES, ON BEHALF OF FEDERATION OF AMERICAN HOSPITALS

On behalf of the members of the Federation of American Hospitals, we would like to thank the Committee for this opportunity to present the views of our organization on national health insurance.

The Federation of American Hospitals is the national association of investor-owned (proprietary) hospitals representing approximately 1,100 hospitals with over 105,000 beds. Our member hospitals range from small rural facilities to large urban and suburban comprehensive medical care institutions. Investor-owned hospitals in the United States represent approximately 25% of all non-government hospitals. In many communities, investor-owned facilities represent the only hospitals serving the population.

Not only do investor-owned hospitals deliver quality health care, they also pay a substantial amount in taxes, amounting to $115 million in federal and state income taxes and $39 million in local property taxes last year alone. It would cost more than $6 million in public funds to replace the beds built by investor-owned hospitals.

Investor-owned hospitals have been founded by local citizens to fulfill urgent community needs, but more significant to the scope of these hearings is the fact that investor-owned hospitals have been able to operate at a rate of commensurate and competitive with the rates of other hospitals. This is true even though proprietary facilities pay taxes and are subject to the same requirements for licensing, accreditation and certification for Medicare, Medicaid, and various Blue Cross programs as are other hospitals. Not only are our hospitals committed to providing quality health care at a reasonable cost, but we believe the free enterprise sector of the hospital field can make a significant contribution in the development of a more effective and efficient health care delivery system.

We appreciate this opportunity to set forth those specific goals which our association believes should be established in drafting national health insurance legislation.

After considering a long list of desirable objectives, we would narrow the major goals of a national health insurance plan to the following two:

(1) Provide a minimum benefits package of health care insurance to all Americans; and

(2) Provide protection against catstrophic costs of prolonged illness to all Americans.

TIMING OF NATIONAL HEALTH INSURANCE

The state of the nation's economy is often cited as the major reason this Congress is not expected to pass a comprehensive national health insurance bill. The economic situation and the huge federal budget deficit also led to the President's moratorium on new domestic spending programs this year.

We would suggest to the Subcommittee that the current economic climate is the ideal one in which to consider the issues involved in drafting a national health insurance bill. Fiscal responsibility and the lowest utilization of public sector dollars would be the necessary ingredients of a health insurance program drafted in this period of fedral spending restraint. That kind of health insurance program, while drafted now, could, and we believe should, be phased into being over a number of years further cushioning the economy from the inflationary impact of sudden increases in demand for health services.

For these reasons we commend your Subcommittee for scheduling these public hearings and urge you to follow this stage of your consideration of national health insurance with an effort to draft a bill which minimizes public sector spending, payroll tax financing, and government administration, and instead maximizes private sector financing, insurance and administration of health protection.

PLURALISM

The general approach supported by the Federation is the restructuring of a pluralistic health care delivery system based on pluralistic methods of financing and administration. We are confident that if competition is encouraged within the health delivery system, the consumer of health care will receive the benefits of a more efficient system. By competition we mean not only competition among providers of health care, but also competition among health delivery organizations, insurers of health care, and financing and administration systems in the health field.

Having concluded that competition can improve both the quality and efficiency of health care delivery, we do not support any program which would place all funds needed to meet the cost of health care in a single entity—whether private or public. For that reason, we oppose the concept of a single federal trust fund managed and controlled by a federal agency. Similarly, we believe that any national program should address itself to the delivery of care as well as the financing mechanism.

A pluralistic system of financing and delivering care will benefit the consumer by offering alternatives. By pluralistic health care delivery system based on pluralistic financing methods, we envision a system in which the federal government and the private sector each play a significant role. In this way, the public and private sectors can work together, compete against each other and offer a planned, manageable and accessible health system to the nation's consumers.

We believe, for example, that the federal government should concentrate on the following areas of priority—first, assuring that those persons without the financial means to pay for needed health care have equal access to the health system and second, that all Americans, regardless of financial means, are protected against the catastrophic or financially burdensome costs of health care. We believe that the private sector, including insurers and providers, can develop an orderly and efficient system for the protection of those working Americans and others who can afford to pay a reasonable price for quality health care that is delivered efficiently and economically. We believe that the impetus to imaginatively restructure the delivery system should and will come from the private sector with encouragement from the government. By maintaining this balance between public and private approaches to the health field, we can assure a dynamic system rather than a stagnant one.

EMPLOYER-EMPLOYEE PLANS

The Federation supports the concept that all employers should be required to provide basic protection against the costs of health care for their employees. This protection should meet minimum federal standards.

We believe that a mandated employer-employee health insurance program should be designed in a manner similar to the workmen's compensation laws, with private rather than public financing.

BENEFITS

We support unlimited inpatient hospital care and physician's services, home health services of 100 visits per year, and well-child care as some of the major benefits that should be included in any package. In addition, the Federation supports the position of equal inpatient coverage for the mentally ill, with expanded outpatient psychiatric benefits. Individuals should not be discriminated against because their illness is not physical. A mental illness can be every bit as catastrophic as poor physical health (and the two often go hand-in-hand), and should be covered equally.

CATASTROPHIC INSURANCE

The Federation supports comprehensive coverage including catastrophic health insurance for all Americans as a part of any national health insurance system. Once the deductible under this major medical type of coverage is met, we believe that all illness-related expenses should be covered. This would include cost of prescription drugs, inpatient and outpatient psychiatric care, dental care, long term chronic illness care in nursing homes and all other illness-related care. Catastrophic health costs in any form should be covered as soon as the annual family or individual deductible is met.

The financing of a catastrophic health insurance program or the financing of the catastrophic illness component of any comprehensive national health insurance bill should in our view be achieved through a combination of insurance purchased in the private sector and the use of general revenues.

We urge you to reject any proposals to utilize a federal trust fund based on payroll taxes as the method for financing catastrophic insurance. Such proposals would expand the Medicare system to cover the major illness expenses of all Americans and would expand the role of the Social Security Administration as regulator, administrator, and payor for health care. Our experience under Medicare for the past ten years leads us to conclude that an expansion of this approach to health insurance would be highly inflationary and unnecessarily complex and costly to administer.

Since the passage of Medicare, health providers have been forced to increase charges to private patients to make up for actual costs incurred but not recognized by the Medicare program. By expanding the Medicare administrative mechanism and its retrospective cost reimbursement system, you would be compounding the inflationary impact of that program caused by increased charges to non-government insured patients.

As alternatives to payroll tax financing and Social Security Administration regulation, we urge the Subcommittee to consider the following suggestions for providing catastrophic illness insurance to all Americans:

(1) Mandated private insurance with employers required to purchase federally qualified catastrophic insurance policies and required to pay a majority of the premium;

(2) An employer financed catastrophic insurance program for the unemployed through continued coverage under private insurance policies previously purchased by employers. This approach could be patterned after H.R. 5970, "The

Emergency Health Insurance Act of 1975," reported favorably by the Ways and Means Committee this past April. To deduct the cost of health premiums, employers would have to purchase policies which meet federal standards;

(3) Tax credits for direct medical expenses which exceed a specified percentage of income. This approach could be coupled with tax rebates for low income families where catastrophic medical expenses exceed tax liability. Administration of this tax credit, tax rebate plan would be under jurisdiction of the Internal Revenue Service and would be less costly and far easier to administer than a Medicare type program; and

(4) General Revenue to purchase private catastrophic insurance for non-employed individuals and the near poor. The Secretary of Labor or the Secretary of HEW would administer this kind of program by negotiating with private insurance companies for group rates based on a pool of beneficiaries. By using general revenues, the tax burden for financing catastrophic benefits would be spread more equitably over the entire population than under a payroll tax.

ORGANIZATION AND DELIVERY OF SERVICES

We have already discussed the importance of stimulating competition among health care providers and others within the health field. The successful reorganization and restructuring of our health care delivery system will depend in large part on continuing experimentation. We do not believe there is any single form of health care delivery which can meet the nation's health needs.

A single form of delivery would destroy the power of the health care consumer to select and shape the system of his choice. For example, while we support experimentation with health maintenance organizations, we would not recommend that all or even a majority of consumers be forced, directly or indirectly, to enroll as subscribers in such organizations. Hospital based HMOs in particular offer a most promising opportunity for initiation of this method of health delivery, requiring a minimum amount of capital expenditures because of the already existing facilities and resources. The effectiveness of a delivery system can only be measured by the relative strengths or weaknesses of competing delivery systems. A delicate balance must be maintained if the consumer is to have true access and true freedom of choice in selecting the system which serves him best.

ROLE OF CARRIERS

In regard to the role of the carrier, the Federation favors an approach in which the carrier acts in the capacity of a private insurance company rather than as a fiscal intermediary. We feel that utilizing carriers in their present role as private insurance companies is the approach most conducive to strengthening competition and providing for the dual administration of the national health insurance program by both the Social Security Administration and insurance companies. There is a great deal of experience and expertise available in the private sector for the administration and design of health plans and it should be utilized. The Secretary of HEW should be authorized to enter into contracts with carriers as administrators of the benefits offered under a system of national health insurance.

The carriers themselves would have to meet federal requirements before they would be qualified to participate in the program. Such a system creates incentives both for employers and insurance companies. Since private employers would be required to provide basic benefits to their employees, they would have the economic incentive to contract with carriers offering the most attractive programs. On the other hand, the insurance companies would have an incentive to keep the cost of the plans down in order to attract business. Thus, the element of competition, as well as free enterprise. is introduced into a program of national health insurance. Such would not be the case if the government were to act as the insurer, because competition would be eliminated, as would the incentive to contain costs.

Some proponents of national health insurance favor carriers as fiscal intermediaries, operating much as they now do under the Medicare program. Competition would be eliminated because insurance carriers would cease to be in business for a profit. There would be no incentive to keep costs of operation down. When insurance companies are permitted to function as private commercial enterprises, they would be more likely to "ride herd" on the billions of dollars in claims that will be filed. With prospective payment systems in effect and carriers competing to contract with employers for the basic benefits package, it would be in the carriers' best interest to monitor claims closely to contain costs.

We are also concerned about the provisions in H.R. 21 for the creation of a Security Board which would have the responsibility of administering the national health insurance program as well as the present Social Security program. The Federation has strong reservations about the creation of such a super agency with such vast controls. We feel that it would be a mistake to place administrative and regulatory power in any one organization, when it is possible to rely on the present system of private insurance companies and hospitals and other providers working together under federal guidelines to administer a national health insurance program.

The Federation favors the creation of a separate cabinet level Department of Health. We believe that the federal government should administer only those aspects of the national health program which are financed by general revenues and the Medicare program.

We would be in favor of establishing an agency within a Department of Health that would monitor the standard benefits package and administration of the overall program, with private insurance companies handling the financing of the mandated employer-employee program and the payment of providers, subject to federal guidelines. Such a system would provide for dual financing and administration of the massive program, rather than entrusting these aspects to a single government agency.

HOSPITAL PAYMENTS

The increasing costs of providing hospital services during the past eight years has brought about a series of arbitrary controls and proposals for government regulation of hospital rates. The Federation has, from its establishment in 1966, called for the adoption of negotiated prospective rates or prospective payment systems as the single most effective device to curb spiralling hospital costs.

Notwithstanding a number of cost-escalating factors, we believe the nation's hospitals can hold the line on inflation given the proper incentives for sound innovative management. To do this we must first rid the system of a prime culprit—retroactive cost reimbursement.

The system of retrospective cost reimbursement has been a major cause of inflation in hospital services because it penalizes efficiency and gives the hospital manager an incentive to increase costs and maximize reimbursement. On the other hand prospectively determined rates provide incentives for efficiency with economic rewards for those who are able to bring effective management techniques to an institution.

There are many types of systems upon which to base the development of prospective rates. These include negotiated charges, a formula to determine payments, group target rates, and rate review boards with the resulting payment based on per diem, per admission, per capita, per procedure or other unit of service.

In order to preserve and encourage a pluralistic health system, we favor the use of multiple prospective payment methods similar to those authorized under H.R. 1. We believe that several prospective rate systems should be developed and that hospitals should have the option of selecting from those approved systems. We commend the distinguished Chairman of this Committee for his leadership in providing for the development of such prospective payment methods to hospitals in his own revised health insurance legislation. We urge modification of those provisions of H.R. 1 to strengthen the role of the federal government in establishing guidelines for multiple prospective rate systems and to limit the power of state governments or state commissions in regulating hospital rates.

We recommend that any national health insurance bill reported by this Committee contain hospital payment provisions similar to those contained in Section 236(5) (A) of H.R. 1 with the following modifications:

(1) The prospective payment methods should be negotiated and developed in the private sector by providers, third-party payors, and other interested parties, under federal rather than state guidelines. The Secretary of HEW would be empowered to disapprove agreed upon systems only upon a finding that the methodology is inconsistent with the federal criteria. That decision should then be subject to both administrative and judicial review;

(2) The federal guidelines should encourage competition among similar providers by providing for payment methods under which similar rates are established for all providers in the same classification based on size, scope of service,

and geographical area. The systems should also assure that rates for an individual institution will not be reduced because of a prior year's efficiency of performance, otherwise a provider will be competing against itself instead of other providers, producing an incentive to increase expenditures; and

(3) Providers should have an annual election from at least three approved payment methods. The election would be made in advance of the providers' fiscal year and there should be flexibility in regulations governing the election.

We wish to commend the Chairman of this Committee for providing that the rate of return for investor-owned institutions projected in developing the payment method should be related to total assets rather than equity. The attraction of private risk capital is essential to meet the modernization needs of the hospital industry and to replace substandard, antiquated beds. That will only happen if the basis for return is related to investments of comparable risk, a fact recognized under Section 212 of H.R. 1. The return on equity under Medicare has certainly proved to be far below any return for investments of comparable risk.

We are confident that the private sector can do the job if given the chance and the motivation. The Chairman's proposals for prospective payment methods recognize that the ingenuity of private industry can produce a better health delivery system. We urge the Committee to act favorably on this approach.

STATE RATE SETTING

Some national health insurance legislation calls for the establishment of state rate setting commissions to determine health provider charges. We reject the idea that hospitals should be regulated as public utilities. There is a crucial difference between hospitals and public utilities—in most communities there are alternative sources for providing necessary health care, unlike the monopolistic system imposed by utilities. Competition can be infused into the health delivery system by utilizing equal bargaining power between hospitals and insurance carriers at the local level. This assures responsiveness to local needs.

Insofar as the Federation is concerned, there is little to recommend about a state rate setting system. Such a system would mean yet another layer of bureaucracy over an industry which is already subject to a great deal of control. The expertise necessary to operate this type of control program at the state level would have to be developed from scratch.

Finally, but quite importantly, it appears that national health insurance in any form will be funded primarily on the federal, not state level. Therefore, it seems unreasonable to delegate to the states responsibility for determining appropriate payment for services rendered under a federal program.

CONCLUSION

There are many other goals which should be incorporated into a national health insurance bill, such as providing appropirate incentives for cost containment, assuring quality of care delivered, choice of delivery systems, access to health manpower and facilities, administrative simplicity and due process. Those objectives, however, do not necessarily require passage of a national health insurance program to be achieved. That is why we hope the Subcommittee will continue its work on comprehensive Medicare reform.

Although the Federation does not endorse any specific bill in its entirety, we believe that the August 19, 1974 draft prepared by Ways and Means provides an excellent start in the right direction. With the exception of the provision for a payroll tax to finance the catastrophic illness protection, we are in accord with the overall approach of the draft and hope that it will serve as a base for further discussions. We believe that national health insurance legisaltion can be enacted which is consistent with efforts to hold down federal expenditures, provided the program is phased-in and does not require massive federal spending, but relies on the private sector for administration.

SUMMARY OF RECOMMENDATIONS

In conclusion, Mr. Chairman, we would like to summarize some of the recommendations that we have made here today.

1. After considering a long list of desirable objectives, we would narrow the major goals of a national health insurance plan to the following two:

   (A) Provide a minimum benefits package of health care insurance to all Americans; and

(B) Provide protection against catastrophic costs of prolonged illness to all Americans.

2. We would suggest to the Subcommittee that the current economic climate is the ideal one in which to consider the issues involved in drafting a national health insurance bill. Fiscal responsibility and the lowest utilization of public sector dollars would be the necessary ingredients of a health insurance program drafted in this period of federal spending restraint.

That kind of health insurance program, while drafted now, could, and we believe should, be phased into being over a number of years further cushioning the economy from the inflationary impact of sudden increases in demand for health services.

3. The general approach supported by the Federation is that of a pluralistic health care delivery system based on multiple methods of financing and administration. We believe that such a system will instill the requisite competition, and the consumer will be the recipient of a more efficient delivery of services.

4. The Federation supports the concept that all employers should be required to provide basic protection against the costs of health care for their employees. This protection should meet minimum federal standards.

5. We urge you to reject any proposals to utilize a federal trust fund based on payroll taxes as the method for financing catastrophic insurance. Such proposals would expand the Medicare system, to cover the major illness expenses of all Americans and would expand the role of the Social Security Administration as regulator, administrator, and payor for health care. Our experience under Medicare for the past ten years leads us to conclude that an expansion of this approach to health insurance would be highly inflationary and unnecessarily complex and costly to administer.

As alternatives to payroll tax financing and Social Security Administration regulation, we urge the Subcommittee to consider the following suggestions for providing catastrophic illness insurance to all Americans:

(A) Mandated private insurance;
(B) Employer financed catastrophic insurance for the unemployed;
(C) Tax credits and rebates for direct medical expenses; and
(D) General Revenues to purchase private catastrophic insurance for non-employed individuals and the near poor.

6. We do not endorse any bill in its entirety, but we believe that the Ways and Means draft of August 19, 1974 can serve as the base for further discussions.

7. We believe that retrospective cost reimbursement is a prime factor in escalating the costs of health care. It should be replaced with prospective rate systems, with incentives for efficient management, negotiated privately by institutional providers and third-party payors subject to federal guidelines.

8. The Federation is totally opposed to state rate setting and recommends that all such references be deleted from any national health insurance legislation. Such vastly empowered agencies with little or no expertise would turn institutional providers into public utilities, causing even greater inflation in health care costs.

9. There are many other goals which should be incorporated in a national health insurance bill, such as providing appropriate incentives for cost containment, assuring quality of care delivered, choice of delivery systems, access to health manpower and facilities, administrative simplicity and due process. Those objectives, however, do not necessarily require passage of a national health insurance program to be achieved. That is why we hope the Subcommittee will continue its work on comprehensive Medicare reform.

Mr. Chairman, we thank you and the Members of this Committee for considering these views and for affording us this opportunity to appear before you.

Mr. Rostenkowski. Thank you, Mr. Williamson.

You recommend the use of prospective payment methods negotiated and developed in the private sector by providers, third-party payers and other interested parties.

You also urge competition among insurers.

I assume that each hospital would be receiving payments from several carriers. Who gets all these parties together? What is the process by which the decision is made as to which reimbursement system the hospital will use and whoever sees the process of negotiation among the various parties and how would disputes be settled?

Mr. Bromberg. Mr. Chairman, I think we have to answer the question on two levels, the national level and the local level. We envision a two-stage process.

First, we would envision the Secretary of HEW as the primary administrator of the program meeting with Blue Cross, commercial insurance companies, other intermediaries and national hospital organizations and perhaps State hospital associations in order to draft three or more outlines of the types of prospective rates that could be acceptable to the Secretary. One might be a negotiated rate system with Federal guidelines, a document that could be distributed to every hospital in the country.

The second might be a budget review type of system and a third might be a formula such as the 75th percentile of average charges for hospital services in the community.

Once those three systems are circulated, State hospitals associations or individual hospitals could sit down with the appropriate intermediary or insurance carriers at the local level and reach agreement.

That agreement would then be submitted to Washington for approval or rejection depending on whether it meets the original guidelines. In order to make the point that this is less complicated and easier to administer than other programs, I would compare it to the State ratesetting alternative which is that 7,000 hospitals and 20,000 nursing homes would come once a year with their budgets in hand to a commission and go through a hearing process plus an appellate process to determine one-on-one each facility's rate.

The system we are proposing instead requires not a review of 27,000 institutional budgets but rather the approval of three or more basic plans and a group negotiation. So I think it would be far easier to administer.

If this were done under medicare as an amendment rather than national health insurance immediately it could be experimental and the results of several years experimenting with this kind of a system could then be brought into effect whenever national health insurance or that phase of national health insurance becomes operative.

The point we would like to make though, is that if national health insurance is going to be a phased-in program and most people think it will be, then it is even more imperative that you amend the medicare law now so that experimentation can start.

Otherwise we will be further behind the ball when national health does become law.

Mr. Rostenkowski. Mr. Duncan.

Mr. Duncan. Do you have information as to how your rates compare with the rates in the public charitable hospitals?

Mr. Williamson. We have not done an exhaustive study to determine our 1,060 hospitals compared with a comparable 1,060. I can only speak to this from personal experiences in Virginia and Tennessee.

Given the comparable, that is, hospitals with the same age, and the same kind of services rendered, we feel that our rates are comparable to that of the nonprofit hospital, community-run hospital.

Mr. DUNCAN. Have your rate increases through the last few years been about the same also?

Mr. WILLIAMSON. Sir, my company, Hospital Corporation of America, last year had an 8-percent increase in our per diem charges which is lower as you can imagine than it was nationally.

Now, this—when you start making comparisons with—throughout the country you have to focus on an area and determine whether or not the hospital is a new hospital, a capital hospital cost or higher or lower and all these comparisons. So it is very difficult to give an answer that is meaningful.

Mr. DUNCAN. I thank you very much for your excellent presentation. Thank you. Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Corman will inquire.

Mr. CORMAN. Thank you, Mr. Chairman.

What have the private health insurance companies done to control the costs of health care, since you are in the hospital business, let us limit it to hospital care.

Mr. WILLIAMSON. Mr. Corman, you raised this point with Mr. McMahon before and from a personal standpoint I do not think that that is the business that the private insurance companies are in. I think you made the very excellent point that there is a financing vehicle and I feel that the private insurance companies should not provide that kind of control.

It is you and your committee and the Government, as you look at this escalating cost where our GNP has gone from 4 percent to now 8.3 percent, we have to be concerned about the aggregate cost of medical care, I think, as opposed to the line-by-line budget review costs that Mike referred to.

So it seems to me that mechanisms like the Public Law 93–641 health planning legislation will be much more effective in controlling capital formation and determining what are the appropriate services to be rendered. Once those services are in place and onstream, the control of those costs, the effect of the control of those costs is going to result in a very minimal kind of benefit. For instance, I think that we find that the so-called margin in the hospital industry now is—depending on whose statistics you read—somewhere between 3 and 6 percent.

So if you were to control the costs to the point where the hospitals were provided no profit margin whatever, which would be terrible, then the aggregate benefit to us would be much less in my opinion than if we were to control the infusion of capital and the appropriate placement of facilities in the first place. So I do not think in answer to your question that it is the role of the private insurance carriers to control costs.

That is, in my opinion, a payment mechanism matter.

Mr. BROMBERG. I would add to that, also, Mr. Corman, the fact that if they wanted to, and I agree with Mr. Williamson they should not, they could not because they do not have a big enough share of the market. Their economic power is not that of Blue Cross where they can come in and demand a discount in many cases. Hospitals think that discount is too much, of course, but if we go to a mandated employer national health insurance system and a large employer with thousands of employees now has to choose from three or four qualified carriers, a couple of which may be commercial, they suddenly may have greater access to that market. Maybe not enough but greater access.

One of the existing problems will at least be improved somewhat.

Mr. CORMAN. I really appreciate your suggestions that we ought to be experimenting with medicare now to find out how we can make improvements. Would you support a provision in medicare that a doctor or hospital could not surcharge the patient over deductibles or copayments?

Mr. BROMBERG. The present law prohibits the doctors from surcharging the patient with only minor exceptions. The committee wrote in a couple of exceptions but for all intents and purposes we have since 1965 been prohibited from doing that. The administration is proposing that there be a copayment by the patient but I do not know of any proposals that would allow a surcharge.

Mr. CORMAN. What has happened on the exceptions we wrote in for the deluxe care? Has that been utilized much?

Mr. BROMBERG. Our understanding is that when it was at 90th percentile there were about 150 hospitals out of 7,000 that exceeded the guideline. When it was reduced to 80th percentile that went up to about 700. But we have not had any direct communications from our members as to an adverse impact of that on them. We did testify against the proposal on the grounds that we thought that the intent of Congress was not followed and the patient mix was not included in the determination of the classification of hospitals, and we testified in September extensively on recommending that the hospital classification system be revised to take into consideration both patient mix and the age of the facility.

One of the problems we see is that the hospital built last year with inflated dollars is put in the same classification as a 75-year-old hospital whose debt is probably much lower and whose construction costs were much lower. So there were problems with it. There was litigation which is on appeal now. In terms of our specific association we cannot give you any detailed list.

We know very few of our institutions that have been refused payment under that section.

Mr. CORMAN. It gets much harder when you get to the doctor's part of the whole thing.

The last time I was home a hospital administrator told me he lost his pathologist because they could not pay him more than $25,000 a year salary. Is that typical or is that the case?

Mr. WILLIAMSON. Mr. Corman, I have heard a number of administrators make the same kind of comment, but I have been an administrator for 19 years; I do know the supply and demand has changed very dramatically, and in the hospitals that we operate, Mr. Chairman, we have not had that problem.

There are 70 hospitals in this group which——

Mr. CORMAN. What is the going rate for a pathologist in your hospital?

Mr. WILLIAMSON. Inasmuch as our hospitals are based on a decentralized kind of system, we do not have one system by which we pay all of our pathologists. It becomes a negotiated kind of rate.

So I could give an average, but that would be meaningless.

However, I do know that in a number of hospitals that I was involved with, we tried to do—what we tried to do is to determine the appropriate professional service rendered by the pathologist and we have negotiated a salary for the responsibility he has with respect to the clinical laboratory, the responsibility he has with respect to the director of the school of laboratory technology.

In addition to that, we have layered on top of that in the surgical area, the kind of charges that are fee-for-service for post mortem examinations, and for surgicals that are done on the patient. In that way we have related a specific kind of remuneration to a professional service rendered. It has worked very well in the hospitals in which this has been attempted.

Mr. CORMAN. Do you have any idea what it has turned out to be?

Mr. WILLIAMSON. In terms of economics?

Mr. CORMAN. In terms of dollars per man per year.

Mr. WILLIAMSON. It would depend on whether that hospital were a 100- or 300-bed hospital. I know one 300-bed hospital in which the income is about $82,000.

Mr. CORMAN. If there were only 100 beds, might it be substantially less?

Mr. WILLIAMSON. Yes.

Mr. ROSTENKOWSKI. One more question: You recommend a system of catastrophic insurance for the unemployed. I am not sure what you have in mind. What is a catastrophic expense for an unemployed person who has no income from work?

Mr. BROMBERG. Obviously the catastrophic cost to that person would be $1 in many cases. I think what we were trying to do in that part of our testimony, Mr. Chairman, was to say that in August of last year this committee drafted an outline of a bill. We believe there was a real consensus in a lot of places, the administration, the Congress, the field, the industry, providers, that 95 percent of that draft was very, very good and very, very acceptable. The No. 1 problem with the draft in terms of how others saw it was the fact that payroll taxes and social security was used in the catastrophic section of that bill and it caused a tremendous amount of controversy. We tried to outline four alternatives that we think would be acceptable as a substitute for that one section.

Perhaps had they been used a year ago, we might have had a draft out of the committee. I think——

Mr. ROSTENKOWSKI. You are more optimistic than I.

Mr. BROMBERG. We are suggesting that perhaps that bill could be taken a step further and have it applied to the unemployed for catastrophic as well as basic benefits.

Mr. ROSTENKOWSKI. Thank you, I see. Thank you very much.

Mr. WILLIAMSON. Thank you.

Mr. ROSTENKOWSKI. Mr. Phillips, Mr. Stratton, Mr. Williamson. Good morning, gentlemen, would you identify yourselves and your associates, please.

STATEMENT OF CHARLES D. PHILLIPS, PRESIDENT, AMERICAN PROTESTANT HOSPITAL ASSOCIATION, ACCOMPANIED BY ROBERT W. STRATTON, VICE PRESIDENT, AND KENNETH WILLIAMSON, LEGISLATIVE CONSULTANT

SUMMARY

Policy.—The development of a national health policy oriented toward assessing and appraising public needs and allocating the health dollar for optimal benefits should be provided for.

Benefits.—A set of comprehensive health benefits could include many services but the American Protestant Hospital Association strongly supports catastrophic coverage in the comprehensive program rather than as a free-standing program. As for specific benefits; family planning, including sterilization and abortion procedures should be provided but not required. In keeping with institutional integrity and in keeping with the concern over ethics and values in health care, humane support services should be provided.

Administration and quality.—The administrative framework should rest with the individual states subject to federal guidelines. The states should be responsible for carrying out federal standards, approving facilities and services, approving rates and charges, and administering an appeals mechanism.

Private carriers should continue their functions as intermediaries similar to that under Medicare and Medicaid. Their administrative expertise could not be readily adopted by a federal agency. Furthermore, as the General Accounting Office recently found, the government employees insurance program's administrative costs were significantly larger than those of private carriers.

Financing.—Health care financing must be pluralistic because of the possibility of under financing. Furthermore strong incentives for philanthropy should be retained. The cost of NHI plan should be divided between employer-employees and the federal government. Private carriers could write comprehensive insurance (meeting federal standards) with the employer and employees sharing the costs. Medical indigents could be provided care through general federal revenues. Payments to institutional providers should be made on the basis of a state administered prospective budgets with provisions for a clearly defined review and appeals mechanism. Rate review and planning should not be the responsibility of one agency.

Institutional integrity.—A large majority of communities in the United States are afforded hospital care through religious and other not-for-profit hospitals. A national health program, to the greatest extent possible, should preserve institutional integrity. Such institutional integrity should include flexibility in operation and incentives for efficient, quality care.

Mr. PHILLIPS. Mr. Chairman, I am Charles Phillips, president of the Protestant Hospital Association. With me is Robert Stratton, vice president, and Kenneth Williamson, legislative consultant.

The American Protestant Hospital Association is a nationwide organization which represents some 265 Protestant affiliated health care institutions, homes for the aging, and agencies, and 1,600 personal members. The national office of APHA is located at 840 North Lake Shore Drive, Chicago, Ill.

The board of trustees of the American Protestant Hospital Association has adopted a 15-point statement on national health insurance, entitled, "Basic Elements of a National Health Insurance Program." That statement, which this testimony amplifies, is not intended to be supportive exclusively of any one approach to national health insurance or of any current bill before the Congress. Nor does the position pretend to exhaust the problems that will be faced by drafters of a national health insurance plan. Rather, the testimony is a presentation of what we perceive, from the standpoint of religiously affiliated not-for-profit hospitals, to be the essential issues which should determine the thrust of whatever legislation is eventually enacted by the Congress.

Religiously affiliated and other not-for-profit hospitals provide a great majority of hospital care for the communities of this Nation. In fact, the religiously affiliated hospitals of all types provide approximately one-half of the acute care beds and in many cases are the only sources of acute hospital care in many communities.

The religiously affiliated hospitals are community enterprises which are sources of cohesiveness and pride to their respective communities. By and large they are operated and managed by the people who benefit from their services. The responsibility for continuing to provide a great volume of health care services under any program of national health insurance will fall upon these hospitals. Therefore, the American Protestant Hospital Association urges that much study, comparison, and analysis be made of proposed and potentially workable approaches before one scheme is adopted and enacted as legislation, and we are very pleased that this subcommittee is taking that approach.

Five major areas are covered in this testimony. They are inclusive of the following: (1) Policy, (2) benefits, (3) administration and quality, (4) financing, and (5) institutional integrity.

I repeat, the approach taken in the testimony is that of a philosophical position rather than getting into a great amount of technicality.

POLICY

First, I speak to policy, if I may. A national health insurance program should be based on a carefully developed national health policy which is oriented toward assessing and appraising public needs and allocating the health dollar so that optimal benefits for the public are achieved. A determination must be made as to what is good health care and how much of its is to be delivered by the system. Research in the last 10 years has put medical care in better perspective and has shown that financing systems have a strong influence on the amounts, kinds, and distribution of services. Surprisingly, however, little data has been collected on what the effects of the services should be. Therefore, the priorities to be given to health care delivery must be defined. The degree to which the Federal and State governments are to be involved with the private sector must be decided.

Health care legislation in the past has been enacted in a piecemeal fashion with each law focusing on a particular problem or set of problems. Some examples of this type of approach are the provision of health care services for the aging under medicare or for the poor under medicaid, financing for hospital construction under Hill-Burton, provision for regional planning under National Health Planning and Resources Development Act, the PSRO's, and legislation encouraging the development of alternative health delivery systems such as health maintenance organizations.

Regrettably, in too many cases, the efforts have been ineffective in correcting the problems they aimed to solve. Because all aspects of the health care system are so intensely interrelated, an attack on one often has created a problem in another. As an example, the medicare law has helped to provide many health services needed by the aging, but it has also been responsible for much of the inflation experienced in the delivery of health care.

A concentrated effort must be made to integrate all the aspects of the health care system as parts of a coordinated whole. National health insurance should be more than just a plan for paying medical bills, although this is one of its primary objectives. It should be a program which assures that our national health care delivery system works for the benefit of all our citizens.

A preeminent objective of a national health program should be the meeting of the health needs of the public without the constraints imposed by insurance principles. Access into the system must be assured for every citizen by eliminating the frequently encountered problems of coinsurance, deductibles, deposits or other cash transferences at the time care is rendered. The national program must delineate the benefits which are available to all citizens and establish payments or premiums which are spread so that they are not experience rated. This approach will eliminate the potential problem of an employer selecting only those employees who are good health risks or who are single or who have small families or other matters which would tend to hold his contributions to the plan down.

The national health insurance program should be broad based and all encompassing. All health programs such as medicare, medicaid, governmental employees—Federal, State, local—armed services plan for dependents and retirees—CAMPUS—Indian health services and health services for seamen should be included. The program should be comprehensive enough to include maternal and child health programs, rehabilitation programs, et cetera. An indepth study, with a maximum of 2 years mandated for a report to Congress, should be provided on how health care for veterans can be included in the national health insurance program.

BENEFITS

As to benefits, a national health insurance plan should provide for comprehensive benefits. Cost effectiveness will be determinative of which benefits are included initially. In keeping with the desire for a unitary health policy, the APHA strongly supports catastrophic coverage in the comprehensive program rather than as a freestanding program. A single comprehensive program should also help streamline and contain the bureaucracy, thus saving administrative costs. As a minimum, comprehensive benefits should include the following: (1) All preventive care for children under 13; (2) massive annual screening of adults, and where indicated, complete physical examinations; (3) provisions for services to motivate and educate people toward good health and preventive measures and to the proper use of health services and facilities; (4) family planning services, including sterilization and abortion procedures with a provision that they need not be offered by all facilities; and (5) humane supportive services which include a positive contribution to patient care and which are a valuable resource in the everincreasing concern over ethics and values in health care.

ADMINISTRATION AND QUALITY

Now, on administration and quality, the national health insurance program should be one that builds upon the strengths of the existing health care system. The success of any program will depend to a large extent on the willingness of those within the program to make it work. Therefore, in order to assure that the administrative framework will take hold gradually and without excessive disruption, the national health program should be phased in over a 3-to-5-year period. Such a phasing in of the national health program will stimulate the reorganization of the delivery system with appropriate incentives for the provision of quality patient care.

The specific administrative framework should rest primarily with the States. State level administration subject to Federal guidelines, standards, and review is preferable to centralization in Washington. An agency as large as DHEW is institutionally incapable of administering such a massive program. States should be responsible for carrying out Federal standards, approving facilities and services, approving rates and charges, and administering an appeals mechanism.

Private insurance carriers should have a place in a national health program similar to their position as intermediaries under titles XVIII and XIX. Their administrative expertise, as demonstrated over the last 10 years, could not be immediately duplicated by another agency. If their function were to be taken by an executive agency of the Federal Government, administrative costs would be shifted from the private to the public sector. The bureaucracy would balloon and costs would inevitably increase. The General Accounting Office in a recent study found that government employee insurance program administrative costs were many times that of private carriers.

The role of private carriers should include the collection of payments for individuals covered, collection of deductibles and coinsurance premiums, and payments to providers. The function of carriers in regard to a payment system to providers would be accomplished at the State level, but clearly subject to Federal guidelines.

Finally, a mechanism should be incorporated into the legislation which assures the continual measurement of the efficiency and effectiveness of the overall program and by which the quality of care can be determined.

FINANCING

APHA supports financing from the broadest base possible. Pluralistic financing is therefore a must. A national health insurance program should specifically include strong incentives for continued donations and charitable contributions to institutional providers. The clear intent of Congress should be so delineated. Such donations should not be required to offset revenue or capital items which are reimbursable.

The program should be financed by employers and employees and the Federal Government—in the case of the aged, poor, near poor, medically indigent, et cetera—purchasing comprehensive benefits from private carriers. The costs of coverage for employed persons should be shared between the employer and employee.

As previously stated, private carriers would reimburse providers for services rendered. However, institutional provider payments should be made on the basis of State-administered prospective budgets with provision for a clearly defined review and appeal mechanism. A State agency should approve prospective rates but the same agency should not have responsibility for the planning of facilities and services. The functions of planning and ratesetting must be kept separate in order to prevent conflicting interests and blurring of functions.

The State rate authority should assure that reimbursement will cover the total financial requirements of institutional providers. Institutional educational costs should be specifically included in reimbursable costs. The medical profession should, in consultation with the State authority, be required to develop a basis of reimbursement for professional fees which will assure quality of care and provide for the review and control of charges.

INSTITUTIONAL INTEGRITY

On institutional integrity, the vitality of this health delivery system, we repeat, is dependent on the willingness of those in the system to make it work. Therefore, as the system is reorganized and appropriate incentives are built in to assure the quality of patient care, the integrity and autonomy of institutions must be preserved, as well as their unique character as institutions of their respective communities. This country traditionally has been a country of choice. A national health insurance program must preserve that tradition, the freedom of the consumer to choose among health providers and the capability of health providers to offer care is a way which is unique to them.

Mr. Chairman, I appreciate the opportunity to present our views. At this time we would be happy to answer whatever questions that you may have.

Mr. Rostenkowski. Thank you, Dr. Phillips.

I notice in your statement you favor the prospective rates for reimbursement. Would you discuss a little further the administration of such a program?

Mr. Phillips. We have not prepared testimony to get into technicalities of that. We feel that H.R. 1 suggests one model by which this may be done, but the principle is that it would be administered at the State level and there would be a system of prospective ratesetting.

Mr. Rostenkowski. Mr. Duncan?

Mr. Duncan. Thank you, Mr. Chairman.

You suggest in your testimony that some reorganization of the health delivery system is desirable.

Could you expand on that thought and give us some idea of what kind of reorganization you have in mind?

Mr. Phillips. First of all, we certainly would support the continued use of the present system, building on its existing strengths. We believe there is room for development of HMO's, and the health care corporations, within H.R. 1. Some of the reorganization would be involved in the general approach of our testimony that the Federal guidelines would be established with administration of the program at the State level and I should have added that we would strongly support in the State ratesetting systems the use of the consumer along with providers and government. We would use the current strengths by experimenting with new delivery systems and then moving it to the State level for administration under the Federal guidelines.

Mr. Duncan. If the States administered national health insurance what would be the best way for the Federal Government to monitor performance of the States without becoming bogged down in bureaucratic redtape?

Mr. WILLIAMSON. Congressman, it is our belief that there is going to have to be checking on whatever the administrative agency is or whoever administers the program. There will have to be a certain amount of Federal oversight. We believe that the development of Federal standards administered by the State, however, should minimize the checking needed. We mentioned that one structure envisioned in the bill, H.R. 1, Mr. Ullman's bill, carries the process one step further as a means of administering the program at the State level under Federal guidelines, with State authority and oversight, but with the State overlooking or overseeing local administration by a local health care corporation to keep the administration as close to the providers as possible.

Mr. DUNCAN. Thank you very much. Thank you for your very helpful presentation.

Mr. ROSTENKOWSKI. Mr. Corman will inquire.

Mr. CORMAN. Thank you, Mr. Chairman.

I would like to focus in just a moment on the continuing role of the charity hospital after we have some kind of national health insurance system. It seems to me that charity must provide for that group and those services that first they cannot provide for themselves, and second, the Government does not provide for them.

When we finish up the national health insurance system, what ought that role be? What should we leave out? The person who cannot provide for himself, and the Government is not going to provide for?

Mr. PHILLIPS. I am not sure—would you repeat your question, please Mr. Corman?

Mr. CORMAN. You are not the first witness this morning that has pointed out to us that whatever we do we must leave a role for charity, for charitable giving.

It seems that looking at the whole range of charity that it provides something which the individual cannot reasonably pay for for himself and which the Government does not provide for him.

In other words, that is where charity has to step in.

Now, in structuring this national health insurance program what is it that you want us to leave out so that charity will have the necessary role?

Mr. PHILLIPS. Mr. Corman, I may be misunderstanding your point but I think you are suggesting at least in my mind, two concepts. We have espoused a strong incentive for continued philanthropic giving. The private donations which—there should be clear tax incentives for that.

Now, you also include——

Mr. CORMAN. We have heard that before.

Mr. PHILLIPS. You also include in your question care to those who can't afford it. You say it in a charitable sense. Then you ask what do we leave out. I don't understand that portion of the question.

Mr. STRATTON. I would say currently under the current Hill-Burton charity care regulations each facility renders a given level of care based on a decision made at the State level to render, based on its operating revenues over a given period of time. Each nonprofit hospital is classed as an eleemosynary institution; it is supposed to give a reasonable volume of care.

Mr. Corman. Yes, but I am looking down the road when we have some form, maybe not the Kennedy-Corman approach with universal and compulsory coverage, but some insurance system. Most witnesses have agreed there will still be a role for the Federal Government to play for care for the poor and near-poor. Then, most folks want us to put into play some kind of insurance system to which everybody else will belong.

But it is important for charity to have a responsibility in health care. If we are referring to research for a cancer cure, I can see that probably still plays a role but is there a place for charity in the health care of individual Americans? If so, how does it fit in with a national health insurance program?

Mr. Phillips. I am not sure that it would fit in under our concept. We consider that those deemed to be poor, medically indigent and others, would be covered under a general Federal revenue program.

Mr. Corman. The Government would pay for it.

Mr. Phillips. Yes, the Government, although I don't think we have specifically left out the possibility of rendering charitable care if the appropriate system was structured.

Specifically, we do not include that as a concept in our package.

Mr. Corman. In other words, the poor would not have to look for charity for their health care; they would look to the Government?

Mr. Phillips. I think so, yes.

Mr. Corman. Who is it that looks to charity for their health care or are you saying there is no role for charity in the health care of the individuals?

Mr. Phillips. I think I understand your question as, for instance, I recently attended a benefit dinner where all benefits from that dinner went to the free bed care of that hospital—a sizable amount in a given year.

And under national health insurance, the proposal that we would support, that kind of care would be provided by the Government through tax revenue for the poor or the near poor.

But in other kinds of programs in national health care, the experimental programs, development of new kinds of resources, facilities, approved, of course, under a certificate-of-need legislation, there still could be a great amount of motivation we think to religiously inclined people to give their dollars to support new kinds of innovative programs.

Mr. Corman. Who will be the beneficiaries? Who is it that will get their health care from this?

Mr. Phillips. The entire community in which that facility operates.

Mr. Corman. But then someplace out there those same beneficiaries are paying compulsory private health premiums. Why is not the insurance company paying for that care? Why must charity pay for it?

Mr. Phillips. There always will be, I think, an offset that accrues to the public benefit because that charity dollar was given. It accrues to the benefit of the Government in its reimbursement if——

Mr. Corman. Oh, then if a hospital for instance gets a million dollars from charity to build a hospital wing, then that would not go into computing what the Government owed that hospital for the care of the poor, is that what you are saying?

Mr. WILLIAMSON. I think, Mr. Corman, in the future if we get into a Government program of the kind we are visualizing, the ability of the health care field to move and change rapidly is needed. If you take 5 years ago, or 10 years ago at most, it would have been impossible for anybody to foresee really the changes that had to take place in medical practice and needs of hospitals to accommodate to it. We think that charity is one means by which hospitals can move much more rapidly in changing things if you will without an institution having to wait for Government action.

I would take an example, it took about 5 years as I remember at Walter Reed Hospital to get new modern beds for their patients. It saves labor, is good for patients, and all the rest. It wasn't until Senator Dirksen fell out of bed in one of those old high hospital beds that they were able to get new beds there. That is a small item, but it is the kind of a thing where a hospital with access to community funds can move quickly, and do something. Without it being a load on Government——

Mr. CORMAN. Or a load on the private insurance carriers.

Mr. STRATTON. Yes.

Mr. PHILLIPS. I believe in answer to your question it would be for the benefit of the charity patients, and it would be for the benefit of all patients in the facility.

Mr. CORMAN. What it seems to me what you are saying then is that the charitable dollars are really going for the benefit of the insurance companies and the Government. Because we anticipate when we get through with all this that we are going to have in place everybody's care paid for by one of those two entities. So whatever charity brings in saves one or the other or both of those dollars—maybe it will be reflected in lower premiums or in lower reimbursement from the Government. I wonder if that is what you anticipate?

Mr. PHILLIPS. Let me get back to you on that.

Mr. CORMAN. Thank you.

[The following was supplied for the record:]

HOUSE OF REPRESENTATIVES,
Washington, D.C., December 3, 1975.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommitte on Health, Washington, D.C.

DEAR DAN: During the Subcommittee hearing on November 10th, I questioned the representatives of the American Protestant Hospital Association about the role of philanthropy in a national health insurance program.

Mr. Kenneth Williamson, a Consultant to the Association, later wrote me a concise and forthright statement about his additional views on this issue.

Mr. Williamson's letter should be a valuable contribution to the Subcommittee's deliberations on national health insurance. Thereby, I ask that his letter be printed in the appropriate place in the hearing record.

With kindest regards,
Sincerely,

JAMES C. CORMAN,
Member of Congress.

KENNETH WILLIAMSON ASSOCIATES,
Washington, D.C., November 13, 1975.

Hon. JAMES C. CORMAN,
U.S. House of Representatives, Committee on Ways and Means, Rayburn House Office Building, Washington, D.C.

DEAR MR. CORMAN: On Monday of this week I accompanied Dr. Charles Phillips when he presented testimony before the Committee regarding the views of the American Protestant Hospital Association on a National Health Program.

During the questioning you asked a very good and, I thought, extremely responsible question as to the justification for continued charitable gifts to private nonprofit hospitals. We felt our discussion of your question was not very illuminating nor sufficiently responsive. This letter, therefore, is to express some additional views just on this matter.

At present and in the past charitable funds have played a most important part in the operation of hospitals enabling them not only to render free and part free care but to meet facility needs, educational needs, research needs and special service needs of the community. Of course, the dependence of hospitals on charitable funds to defray the costs of care to the poor and the near poor has been lessened appreciably by Medicare and Medicaid and by the private insurance programs.

However, there remains a substantial need in addition to these various sources. It is expected and hoped, of course, that any National Health Program which the Congress passes will defray the costs of health care needed by the poor, the near poor (medically indigent), the unemployed, etc., and, thus, the need for hospitals to rely on charity funds for these purposes would be lessened. However, as of now there is no real assurance of this and, in fact, it is our belief that a proposal such as that which the Administration previously introduced would leave appreciable numbers of persons without assured financing for their health needs. Also, it is not unlikely that a proposal such as the Long-Ribicoff catastrophic approach could leave a sizeable number of people without assured financing because their private health insurance is so poor and inadquate. In fact, as we see it, the passage of any proposal along the lines of these two examples might well increase greatly hospitals' patient care financing problems and, thus, an even greater need for sustaining charitable contributions.

Under even a very broad program of benefits and protection, hospitals face a considerable need for funds that can be applied to given situations rapidly and on the basis of the individual judgment of the hospital authority. Meeting such needs that are in the interest of the community served cannot await clearance through the governmental hierarchy. The health field, and medical care in particular, is changing too rapidly for anyone to foresee at any given point exactly what changes may occur and what improvements can be made available. Thus, hospitals need to be free to move quickly in providing for research, for various immediate educational needs and for the purchase of numerous "things", all of which could serve to benefit patients and the community.

We believe, of course, that the voluntary Board of Trustees of the private church hospital provides an extremely important link between the community and the hospital. In a church hospital we believe this form of service to be especially important and of such value to the community that it should be preserved in every way. Charitable giving and the whole mechanism of encouraging individuals to provide gifts to hospitals to support their activities is a very important part of the interest and motivation of these voluntary Boards. Afer all, whatever is done for a nonprofit private institution can only go to advance the services and, thus, to benefit the public. There is simply no other purpose for the funds.

One major area I would like to bring to your attention is in respect to the capital needs of health care institutions in the future. I believe your bill is the only one that really visualizes the continuing needs of hospitals for capital funds to provide facilities and services needed and to renovate and change existing facilities as well as to provide new ones as needed. However, generally the health insurance proposals that have been introduced do nothing to meet these future capital needs. In fact, they seem to presume that whatever national program is passed, it will buy into the system and that somehow the facilities and services will be there and available. This, of course, is sheer nonsense. The provisions on this score which you have incorporated into your bill recognize the reality of the situation.

Therefore, lacking any real assurances as to the kind of proposal the Congress may finally enact and lacking any assurances as to how and whether these capital needs of hospitals will be provided for, the insistence upon provisions assuring charitable contributions and tax free gifts to hospitals is of enormous importance.

We really appreciate very much your asking the very direct question which you did, and I hope this additional information will be helpful to you and the Committee in respect to your considering the future need for charitable gifts and contributions to private nonprofit health care institutions.

With kind personal regards,

KENNETH WILLIAMSON.

Mr. ROSTENKOWSKI. Mr. Martin will inquire.

Mr. MARTIN. Thank you, Mr. Chairman.

Mr. Phillips, some other witnesses that have appeared from time to time on the various panels we have had before the subcommittee have argued that the comprehensive reorganization of all aspects of medical care, health care, delivery, access, and so forth, would be too massive an undertaking to entrust to just one or two consecutive sessions of Congress. Therefore, they came to the conclusion of advocating that we proceed with that digestible or assimilatable-sized components, in modular fashion, dealing one step at a time with those pieces that had the highest priority in terms of shortcomings that might be analyzed under the national health care system and in order of our ability to deal with them.

I take it you are opposed to this and favor instead a unitary approach because of the unhappy experience with the previous legislation which has been written in a piecemeal fashion.

Could you amplify on that argument a bit more? I need to know exactly why you oppose the stepwise approach. Is it because you feel the previous legislation was inadequate? Was it poorly drafted? Is its inadequacy just because it dealt with one piece of it at a time?

Mr. PHILLIPS. I think it would go back to our belief of the need for a health concept in this Nation. We certainly support phasing in. That is a very definite part of our testimony.

But the phasing in needs to be done with a view to how the end is going to—at least initially, how it will be envisioned to turn out so it isn't a piecemeal, unrelated approach.

Mr. MARTIN. And you are unhappy with out national health policy now and you think Congress should rewrite that?

Mr. PHILLIPS. Well, national health policy is a fairly newly written document, Mr. Martin. It is still in the process.

Mr. MARTIN. Testimony received in the past has been that the unwritten health policy has been determined more by providers than by Congress or consumers. You are advocating that Congress balance those interests and rewrite a national health policy? Reorganize the entire system?

Mr. PHILLIPS. It would be by act of Congress that policy would be established but certainly with the input and the consultation of the providers and consumers. No unilateral approach should be taken.

Mr. MARTIN. Why would you object to taking one piece at a time? You particularly here single out catastrophic and say that should not be dealt with as a separate issue. It would seem to me that this subcommittee could do more to resolve that and later move to another question such as the issue of unemployment premiums that we dealt with earlier. Would you comment on that? Why must we try to deal with the package as a whole?

Mr. PHILLIPS. The AHA testimony given this morning deals very well with the disadvantages of going singly with catastrophic coverage and we support those statements.

Mr. MARTIN. I looked over that and it seems to be arguing that—along this line, that (*a*) since previous legislation was unsound or had pitfalls or was inflationary, and (*b*) since the previous legislation was piecemeal, therefore, (*c*) the conclusion is that the shortcomings of the legislation are attributed to the piecemeal nature of it. And that, therefore, comprehensive legislation will avoid those kinds of shortcomings.

Now, it would seem to me that you are simply proposing that the same legislative talent that produced the faulty piecemeal legislation now be applied to reorganizing all aspects of health care.

Mr. Williamson. No, I think, Mr. Martin, our point of view is that the catastrophic being talked about by everyone now is largely a misnomer. The first potential catastrophe facing the public is within what they face in 10 days of hospital care and everything involved with it.

Until that broad program of what we call basic coverage is assured to all the people they face their real potential catastrophe. What we are saying is that we should visualize what we don't now have and that is a national goal for our health program. We should realize what we are starting with, the financing needed, the benefits provided, and then establish phases in which we can reach that goal. Now we have no such goal and we have no phasing in. We just bite out a piece, which seems to us very different than phasing in of a national goal.

Mr. Martin. I apologize for my inability to state my question provocatively enough to generate what it is that leads you to think that the Congress that can't deal with legislation piecemeal can all of a sudden muster far greater insights and talent to deal with it in a comprehensive reorganization.

But, thank you.

Mr. Williamson. We believe the Congress itself, it seems to us, Congressman, should realize its own piecemeal approach has not done the job and that it needs to stop and look at the whole ball of wax and arrive at an intention and a goal and the steps needed to fulfill it.

Mr. Martin. I have no further questions, Mr. Chairman.

Mr. Rostenkowski. Thank you, gentlemen.

Mr. Cruikshank, please.

STATEMENT OF NELSON H. CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY ROBERT GRAY, RESEARCH DEPARTMENT

Mr. Rostenkowski. Welcome to the committee, gentlemen. Would you identify yourself for the record and proceed with your testimony.

Mr. Cruikshank. Thank you, Mr. Chairman, and members of the committee, I am accompanied this morning by Mr. Robert Gray from our research department with your permission.

I am Nelson Cruikshank, president of the National Council of Senior Citizens. I appreciate the opportunity of appearing before this committee this morning on this very important subject.

Mr. Chairman, I have sent over the copies of the full statement and with your permission I would like to have it introduced into the record.

Mr. Rostenkowski. Your entire statement will appear in the record.

Mr. Cruikshank. Then, because it is fairly long, I would like to have the opportunity to summarize it and perhaps comment on some parts of it.

At the outset, I would identify our organization as a federated group of some 3,500 different clubs and senior centers over the United States, now in every State in the Union. We address ourselves to the question of why an organization composed of clubs of all senior citizens should be interested in a comprehensive national health program when we have medicare which was enacted some 10 years ago and has been in operation now some 9 years.

The reasons really are that we feel that medicare has demonstrated a number of points that are of interest, since it is really the only national health insurance program that is in effect, we have some lessons that we have learned from its operation. Our membership consists of persons who are living under a health insurance program, and we should have learned some things from it. But beyond that, Mr. Chairman, we feel that since medicare itself was adopted and enacted with the interest and aid and support of all segments of the population, of all ages, that these group interests are indivisible. The matters that affect the older people affect the middle aged and the younger people just as well.

Today the National Council of Senior Citizens comes before you in wholehearted support of national health security for the total population as proposed in H.R. 21 by two distinguished members of this subcommittee, Mr. Corman and Mr. Vanik.

The identical proposal is designated as S. 3 in the Senate. In one respect I submit the group I represent is particularly qualified to make recommendations to this subcommittee with regard to the various proposals you have under consideration in the field of health care. Our group of senior citizens is representative of the over-65 age group covered by medicare, and medicare remains today by far the Nation's largest public health insurance operation. Most of us have had nearly 9 years experience with medicare. We are grateful for its having relieved us and our families of the major portion of the economic burden of health care costs. But we have also experienced first hand its weaknesses and shortcomings. It is this experience we draw on in the hope that it will be helpful to the Congress in devising a national health plan that will be better than medicare, in all respects.

Medicare, unfortunately, has deteriorated over the last few years of its operation. When it first started it paid some 44 percent of the total health care costs of the older population; it is now paying some 38 percent.

These averages may be somewhat misleading, however, as still the very large bill for a hospitalized illness is paid for in a much higher proportion than these overall averages would indicate.

We believe that one of the major lessons that comes out of medicare experience is that the insurance approach, whether it is public or private, is not the most constructive approach to the health problems of the country.

The insurance approach is designed to protect against the risks of certain types of costly medical treatment. It does not directly deal with people's actual health needs. This approach contributes to the excessive use of costly medical care, especially hospitalization and surgery, when this care is not warranted by people's real health needs. The mere fact that some types of care are covered by insurance encourages providers to use them, and this practice inflates unnecessarily the costs of care. On the other hand, entire areas vital to health care, particularly preventive care, are neglected, because they do not fall within the concept of "risk" upon which the insurance approach is based. I hope I am not speaking here, too lightly of a problem we refer to as the "insurogenic" diseases and the insurogenic procedures. The very fact of coverage encourages the resort to some of these procedures and to some of these types of coverages and protections.

National health security, as contained in H.R. 21, takes an entirely different approach, and we think that its approach is one of the fundamental reasons why it deserves analysis and enthusiastic support of the people of the country and the Congress. For one thing, it takes this $109 billion industry and for the first time begins to budget it and put it under some kind of direction.

Here we have one of the largest industries in the country operating without a plan, without a budget, one of the very largest really operating as, what has been characterized as a "cottage" industry.

The use of co-insurances and deductibles by both medicare and commercial health insurance is an obstacle to effective health care. That is omitted or left out—or "avoided" is the more proper term—with respect to H.R. 21.

If these devices, which that are always being introduced into any health insurance, whether public or private, are effective controls on utilization, they are effective only for the poor and not the well to do.

So this is one of the most unjust approaches to the problem of utilization if indeed it is a problem.

Based on our experience with medicare, we submit that there are six major criteria by which health care proposals should be evaluated.

These are: (1) Universality of coverage, and the uniformity of benefits; (2) reform of health care delivery; (3) provision for Cost and Quality Controls; (4) provision for consumer representation in administration and operation of the program; (5) adherence to school insurance principles in administration and financing; (6) comprehensiveness of benefits.

Our position in support of national health security is a result of our measuring by these criteria the major proposals that have been brought forward. In the long statement here, there are 16 pages, Mr. Chairman and members of the committee, that are devoted to applying these six criteria to the proposal before you. I have submitted these in somewhat different from at different times to the Congress in the hearings of committees previously, so in following the direction which you sent to us and all participants in these hearings, I think it is better for me not to detail them here now, except to summarize them.

We have compared the health security bill, H.R. 21, particularly with H.R. 10028, introduced by Mr. Waggonner of the Ways and Means Committee, and in the Senate by Senator Ribicoff and Senator Long. The detailed analysis is before you. But the sum total of it boils down to this, that we find that only H.R. 21 measures up positively to all of these criteria, to all of the six criteria that we have set forth here. And that H.R. 10028 meets not a single one of them. It fails on all of the criteria which in our judgment come out of the experience that we have had with medicare.

In fact, H.R. 10028 ignores all of the lessons we have learned or that we think we should have learned from 9 years operation of medicare.

With that brief summary, I would turn in my statement to page 21 to the matter of the reform in medicare and medicaid programs. We recognize that our objectives of H.R. 21 are long-term objectives, and while we don't believe it necessary to keep continuously postponing the big steps that must be made, we also recognize that there are some intermediate steps.

Mr. Chairman, I am a senior citizen, I think I testified before this committee before any one of you gentlemen were elected to Congress. I testified on national health insurance in this very room in 1945. That is a long time ago. And I was testifying then in support of the Dingell bill which was introduced by the father of one of your distinguished colleagues, not on this committee, but in the House, as you know.

Why must we after 30 years be told that we must not rush into a major reform and a major step forward but we have to wait and take little steps for little feet?

I think that the people of the country are ready to move forward, I think they are ready to move forward in substantial ways and I think they are ready to make major changes in our health care delivery system.

When we were testifying for medicare and in fact in testifying for that old bill, the Wagner-Murray-Dingell bill many years ago, we were saying, "leave the system alone, provide a method of financing," because I think we were voicing the temper of the country and the people at that time.

If our soundings are correct, however, the opposite is true today. People are saying don't pour more money into this system through mere mechanisms for financing. Do something fundamental about changing the system and provide a logical method of paying for it when we have budgeted for a logical system.

If there is an interim period, and of course I think even if Congress should enact a thing as far reaching as H.R. 21, as it is contemplated in the bill itself, there would be a phasing in period. In that period, however long it must be, we maintain that there are important changes that should be made in the medicare program in the interim.

I have detailed these in my statement and also pointed out why we must be opposed to the so-called "Comprehensive Medicare Reform Act" of H.R. 1939.

In our proposal, we feel that we should merge the medicare and medicaid in a federally administered program covering all residents 65 and over and all other social security beneficiaries in the adult categories receiving cash assistance under the supplemental security income program. Part A and part B of medicare should be combined, therefore, eliminating the premium for part B.

Benefits now provided under medicare would be expanded and payable without co-insurance or deductibles.

Inpatient nursing home services regardless of prior hospitalization should be covered for up to 120 days and without limit if they are furnished in a nursing home owned by or affiliated with a hospital or in a comprehensive health service organization.

We firmly believe that the time has come in the medicare program to move beyond the complicated and confusing procedure now involved in determining the so-called reasonable charges, charges on an individual doctor by doctor basis. In place of the present procedure, we believe that doctors should be reimbursed on the basis of established fee schedules.

All direct billing of patients should be eliminated. This is one of the most serious weaknesses of the medicare program, one that allows a direct billing with no limit to the additional charges that can be added by a physician beyond the reasonable charges.

And the Social Security Administration, under the threats, almost the blackmail threats of the American Medical Association, has refused to notify beneficiaries when these charges are added. Instead, the Social Security Administration simply puts on the bill some such ambiguous phrase as "Not covered by medicare," or "Beyond the covered charges" or something of that sort. They refuse to require the carriers to notify the benficiary that the doctor has added something beyond the reasonable charge as determined under the provisions of the act.

One of the worst features of the direct-billing provision in medicare is that it gives the doctor the choice of how to collect his fees. He can bill directly one day to the same patient and take the assignment method next. He can choose the patients to whom he can give the direct billing, and then choose other patients with whom to take the assignment method and accept the 80 percent of reasonable charge as payment in full, thereby avoiding the risk of not collecting payment from them.

A comprehensive study made by Robert Nathan Associates shows that the assignment method is largely given to the very poor, to the people from the ghetto areas of the central cities; and to the patients with very large bills. The doctor reserves direct billing for middle-class people with middle-price bills—bills to which the doctor feels he can safely add on extra charges without the risk of nonpayment.

This is a very serious weakness in the present system.

Mr. CORMAN (presiding). I will interrupt you for just one moment because when the Chairman gets back I have to go vote and you may be gone before I return. I want to tell you that I think you are one of the most perceptive and logical witnesses that ever appeared before this committee on this particular problem, not just for national health insurance, but of medicare. I think medicare's system is about to destroy itself as far as the beneficiaries are concerned if we permit continuation of what you have been testifying about. Now, I must interrupt in case you are gone. I did not want the record to be silent on my respect for you.

Mr. VANIK. Mr. Chairman, I will second that motion.

Mr. CRUIKSHANK. Thank you.

Mr. MARTIN. Just one brief question. Mr. Chairman.

Mr. Cruikshank, you state that you believe the American people are ready to reorganize medical care and apparently by implication you must believe the American people are ready to support a comprehensive Federal financing whereby the Government would pay all your bills for all your ills with no restraints of deductible or copayment cost sharing. I would like to ask you what you base this on? Have you taken some soundings or surveys that indicate this is true?

Mr. CRUIKSHANK. There have been various polls and I get out over the country a great deal. We have national conventions where people come in—about 3,000 in number—and this——

Mr. MARTIN Is this a cross section of the population?

Mr. CRUIKSHANK. No; I wouldn't say they are a cross section because in our particular group, they are the older people. But older people are in touch with their families; I think they reflect closely what is happening. We could be mistaken, but these are our soundings and I think that as we hear what people are saying, what they are writing to us, and what we see in some of the polls, these communications indicate that there is a basic dissatisfaction with the health care delivery system as it is now operated.

Mr. MARTIN. What do you think would be the result if you or we or someone were to survey the public and ask them if they were willing to increase their taxes by a fourth, to cover the $100 billion in order to pay all costs of everybody without any deductible restraints? What do you think the answer to that would be?

Mr. CRUIKSHANK. Well, I think, sir, if we asked them that question, they would say, "Don't do it." But that is not the question, I believe, if I may respectfully say so, that is really before us.

Suppose we should ask the population the question, "Would you be willing to have some of your taxes increased in modest amount to provide a general pooling to pay for health care and to pay for preventative services which would reduce the total health care costs; and which would relieve you of the burdens of the doctor's bills and hospital bills which you are now paying?"

I submit respectfully, sir, that it wouldn't quite be fair to ask people whether they wanted to pay more in one category without also showing that this payment would relieve them of payments in another category.

I believe the answer to that question, fairly put, would be affirmative.

Mr. MARTIN. I think your phrasing of the question is very apt with one exception, I don't think you should leave the word "modest" in there. I think you should be a bit more precise and share with them what you think the program would cost. Estimates of the program which you advocate are somewhat on the order of $80 to $100 million.

Mr. CRUIKSHANK. We are paying $109 billion now, sir, for health care which is of questionable quality in many areas.

I think there is a fallacy which has appeared in many discussions of this issue, and that fallacy is that only those costs which show up on the Government budget sheet are real costs.

Now, witnesses have been here and talked about how much cheaper their program is because of a much smaller figure which shows up in the Federal budget, and then they talk about a mandated health program in which employers would pay for the health insurance.

Now, the only way that such a plan would show up in the Federal budget is in a way which they have failed to point out, and that is that those costs would be the cost of operation, and these costs would show up in a reduction in the employer's corporate income tax.

So, there would be a reduction of income to the Federal Government with that kind of an approach; but it actually wouldn't reduce the health care costs of the people of this country by one nickel.

Mr. MARTIN. I am willing to have that question put any way you want to qualify. I bet you the public does not want to add $80 to $100 billion to the Federal tax take. But that is apparently where we have different insights.

Mr. CRUIKSHANK. I would be willing to take this issue to the country if you are willing to add $100 billion—it would never be that, but this covers many things that are already covered by costs. I would say x billion dollars if you were relieved of x billion now being paid out of your pocket which is what our bill would propose then would you be willing to add the x billion through taxes to a pooled fund out of which health costs could be budgeted?

Mr. MARTIN. It would be an interesting question and I would like to see the outcome of it.

Mr. CRUIKSHANK. And you and I and Mr. Gallup will have to get together and propose a question.

Mr. MARTIN. Thank you.

Mr. ROSTENKOWSKI (presiding). Would you like to complete your statement now, Mr. Cruikshank?

Mr. CRUIKSHANK. Yes; if you wish.

One of the reasons for opposing the so-called medicare reform bill, Mr. Chairman, to which I have referred, is that we believe the brave claims of the title, that it provides health care for all the aged, is substantially contradicted by inclusion of a number of features in the bill. One to which we object very strongly, Mr. Chairman, is the one that divides the elderly population into classes by income. We think this division has an invidious aspect to older people; we think it would be extremely difficult to administer, because, for one thing, people would move in and out of those classes and, at the same time, they would move in and out of various areas of States throughout the country. It would really be an administrative monstrosity.

When it is really boiled down to its essence and stripped of its rhetoric, this bill provides that the Government would underwrite the health care costs of all of these people who, after the application of some kind of test, were found to be in need. In other words, it would pay the medical costs of people only when they had gone in to some agency and proved that they had been failures in life. Why does it pay their costs? Because there is no money for commercial insurance in protecting the poor people.

But the bill would leave the group of people who had money enough to pay premiums, it would leave that large group to be covered by commercial insurance. Now, there are some good features about that bill, but these things we think are fundamental and fundamental as flaws in the bill.

Then we have the whole issue of the role of the commercial insurance. I think this is one of the most crucial questions that we have. We hear talk about the commercial insurance; we hear talk about the pluralistic aspects of our society; we hear talk about the strengths of our present system of health care.

Commercial insurance is not one of the strengths; it is one of the main weaknesses, because it encourages all kinds of bad medical care. It encourages high costs, it encourages excessive utilization; it discourages preventive medicine, and it requires unnecessary administrative costs that don't contribute to health care at all.

There is a great myth that has developed about the sacredness of this so-called "private enterprise thing" in health care, which we just don't think belongs there at all.

Why we have to keep paying obeisance to this great god of private profit in health care, I don't understand. We sometimes look with either pity or disdain on the mother who tosses her baby into the sacred Ganges as an act of religious worship, but we commit the same sort of act by tossing our older people and many other people into the sacred Ganges of commercial insurance because it is supposed to be some kind of a sacred institution. With regard to these sacred institutions; we should ask what do they do, they is their function that positively improves the health care of the people in the United States?

We have had commercial insurance in health since 1908, in the beginning of our workmen's compensation programs. And I say that they have done nothing but cause deterioration in the level and the quality of health care, but add unnecessary costs, and do nothing but rake off the cream of people's premiums.

I believe this is an essential question that is basic to the whole problem. If we can start planning for the health needs of our people and start budgeting for those health needs and bringing in a method of financing which supports the needs and the the programs, rather than building the program around a method of financing, we will have made a step that is necessary and urgently called for by the people of this country.

Thank you, Mr. Chairman. That completes the summary and some extensions of remarks as you have noticed from my statement.

[The prepared statement follows:]

STATEMENT OF NELSON H. CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, Members of the Health Subcommittee of the Ways and Means Committee, my name is Nelson H. Cruikshank. I am President of the National Council of Senior Citizens. Our national headquarters office is at 1511 K Street, N.W., Washington, D.C.

The National Council is a nonprofit, nonpartisan organization of 3500 older people's clubs in all states. We are the country's largest organization of senior citizen clubs.

While the National Council of Senior Citizens was born in the long fight for Medicare, our objective is a better life for all Americans, young and old alike, and we want to be sure that a better life for the elderly is in harmony with the total national interest. We are, therefore, vitally concerned with the overall national health insurance proposals which this Subcommittee is considering.

We are fully aware that older people could never have achieved the valuable protection of Medicare without widespread support from the younger population. Workers supported Medicare because they viewed protection against medical costs in old age as an important right for their future retirement years as well as an immediate need for their aged parents and grandparents. Medicare has relieved much of older people's heavy medical costs, lessening the need to seek help from family or public welfare in meeting crushing medical bills.

Today, the National Council of Senior Citizens testifies as a wholehearted supporter of National Health Security for the total population, as proposed in H.R. 21 by two distinguished members of this Subcommittee: Mr. Corman and Mr. Vanik. The identical proposal is designated S. 3 in the Senate, where, of course, its prime sponsor is Mr. Kennedy.

In one respect, I submit the group I represent is particularly qualified to make recommendations to this Subcommittee with regard to the various proposals you have under consideration in the field of health care. Our group of senior citizens is representative of the over-65 age group covered by Medicare, and Medicare remains today by far the nation's largest public health insurance operation. Most of us have had nearly nine years experience with Medicare. We are grateful for its having relieved us and our families of the major portion of the economic burden of health care costs. But we have also experienced first hand its weaknesses and shortcomings. It is this experience we draw on in the hope that it will be helpful to the Congress in devising a national health plan that will be better than Medicare.

Medicare, unfortunately, has become less effective in meeting the medical costs of the elderly in recent years. In 1974 the proportion of older persons' medical expenses paid by Medicare was 38 per cent, compared with a high of 44 per cent in 1969. Direct, out-of-pocket expenses to the elderly have actually increased since the program began, from $237 in fiscal 1966, the last year before the start of Medicare, to $415 in fiscal 1974. The primary causes of this trend have been increases in the amounts paid in deductibles and coinsurance, the alarming decline in the number of physicians who accept assignment for "reasonable charges" under Medicare, and, of course, the extremely inflationary increases in the cost of medical care itself.

We have found that one of the major obstacles to adequate health care lies in the limitations of the insurance approach, an approach which Medicare shares with commercial health insurance. The insurance approach is designed to protect against the risk of certain types of costly medical treatment. It does not directly deal with people's actual health needs. This approach contributes to the excessive use of costly medical care, especially hospitalization and surgery, when this care is not warranted by people's real health needs. The mere fact that some types of care are covered by insurance encourages providers to use them, and this practice inflates unnecessarily the costs of care. On the other hand, entire areas vital to health care, particularly preventive care, are neglected. because they do not fall within the concept of "risk" upon which the insurance approach is based.

National Health Security, as contained in H.R. 21, takes an entirely different approach: it begins with peoples' health needs themselves. Health Security allocates pre-existing medical resources on the basis of people's real needs, and it has the mechanisms necessary to generate new and innovative programs to fulfill needs that are now being met inadequately. It is not committed to the old idea of merely spreading the risk of costly treatment, the idea which provides the rationale for close relationships between medical providers and insurance carriers in which the health needs of the patients are too often neglected. Health Security promises, instead, to control unnecessary expensive care and, at the same time, to improve the quality of care by relating it directly to health needs.

The use of coinsurance and deductibles, by both Medicare and commercial health insurance, is also an obstacle to an effective health care system. During recent years, there has been much debate over the real effect of such devices on the utilization of health services. There is considerable evidence that utilization is reduced only when coinsurance and deductible rates are high—that lower rates are nothing more than administrative nuisances that do not effectively control utilization. Regardless of diverse findings, one fact is quite clear: insofar as coinsurance and deductibles are effective in holding down costs, they deprive the very people whom the system should be designed to help. It is the poor, not the well-to-do, who will go without health care, thus increasing inequities and aggravating the health care problems of all but the more fortunate.

Based on our experience we submit there are six major criteria by which health care proposals should be evaluated.

These are:

(1) Universality of Coverage; Uniformity of Benefits.

(2) Reform of Health Care Delivery.

(3) Provision for Cost and Quality Controls.

(4) Provision for Consumer Representation.

(5) Adherence to Social Insurance principles in Administration and Financing.

(6) Comprehensiveness of Benefits.

Our position in support of National Health Security is a result of our measuring by these criteria the major proposals that have been brought forward. What follows is an analysis of that evaluation.

1. UNIVERSAL COVERAGE, SINGLE STANDARD BENEFITS

A single system would assure the individual of the care needed for a particular condition regardless of age, income, residence, or employment status.

Most of the pending national health insurance proposals allege to support the ideal that good health care is not an ascribed privilege but an earned right, like police protection or education. Only National Health Security guarantees this right through a single universal system, without a means test and with the same benefits for everyone.

We may contrast this uniform coverage with the coverage provided by the Catastrophic Health Insurance and Medical Assistance Reform Act, sponsored in the House as H.R. 10028 by Mr. Waggonner of this Subcommittee, and in the Senate as S. 2470 by Mr. Long, Mr. Ribicoff, and others. The catastrophic bill would provide for at least three different types of coverage: the catastrophic health insurance itself, designed to provide benefits after a person has incurred $2000 in medical expenses and/or 60 days of hospital costs; a medical assistance plan for the poor and others who cannot afford to purchase protection against medical costs below the levels of catastrophic protection; and, a certification program for private health insurance policies to provide voluntary coverage for those who can afford it.

These divisions within the bill create at the very outset different classes of individuals who will be insured differently. Even the catastrophic part of this legislation—the very heart of the bill—is split into a private catastrophic plan, in which employers provide protection to their employees through private insurance companies, and a public plan for those not protected as a condition of employment.

These divisions can do nothing but perpetuate the administrative snarls which now handicap the good provision of care. Instead of a single standard of protection administered uniformly, we would continue with the present patchwork network of protection. There would be excessive and unnecessary confusion in trying to keep track of all the different types of coverage available and in attempting to determine which persons are eligible for which types of coverage.

The catastrophic portion of this bill, whether public or private, is simply inadequate to protect persons against the medical costs which are most commonly incurred. Individuals and families can easily be damaged financially by incurring medical expenses well below the levels of catstrophic protection. The possibility of such financial damage is not adequately prevented by the other portions of the bill.

We strenuously object to the concept of income testing upon which the medical assistance plan is based. Income testing runs counter to the basic social insurance concepts currently exemplified in Medicare. Lost entirely under this plan is the concept of medical benefits as an earned right. Instead, the medical assistance plan would be financed entirely from general revenues, and would in reality become a giant medical welfare program for the poor, larger even than Medicaid, which it would absorb. Such a plan represents a real step backwards from the progress that was made under Medicare toward uniformity of benefits. The use of a means test creates an inherent distinction between the poor and the more well-to-do which invariably must lead to different standards of care. Moreover, a means test—no matter how palatably introduced—represents a humiliating form of condescension which no person should be forced to endure in order to receive such a basic service as medical care. Its use will inevitably discourage and prevent the poor from seeking and receiving adequate care.

The program of H.R. 10028 for certification of health insurance policies allows too much possibility for gaps in. and for different levels of, coverage. The fact that the program is voluntary means that some persons will be without coverage through default, not necessarily their own. Especially vulnerable would be those persons whose incomes fall just above the low-income requirements of the medical assistance plan. Unless they were fortunate enough to receive protection through their employer, they would have to purchase a certified policy at a price which could easily be prohibitive. And even through the certification program would require each policy to conform to certain standards, there would remain considerable space for these policies to contain different benefit levels. It is quite clear that persons with higher incomes, or with better conditions of employment, will be able to have better insurance protection.

As we view it, then, the Catastrophic Insurance bill, from top to bottom, would perpetuate different levels of care. In contrast, Health Security provides a single standard of comprehensive benefits, uniformly administered. Health Security represents a unifying force for our nation, much as the introduction over 100 years ago of public education, by overcoming basic social and income divisions in providing a very basic service to everyone.

2. REFORMS OF HEALTH CARE DELIVERY

The National Council of Senior Citizens cannot support a national health insurance proposal which does not make health care reform a primary objective. An acceptable proposal must have the financial muscle to make major improvements in the organization and delivery of health care.

It is insufficient to provide simply a method of payment that will greatly increase the effective demand for a limited supply of health services. Measures must also be included to provide some control over the economic processes of the health care industry and to stimulate an increase in the supply of health services. Our health system needs corrective surgery, not "band aid" reforms.

When Medicare was being formulated all of us—proponents of the plan and our representatives in Congress—were constantly assuring the medical profession, the hospitals, and, indeed, the public, that we were not proposing to alter the system in any way. We were simply proposing a method of payment for health services within the existing system. I'm convinced the public as well as health care providers wanted, even demanded, such assurances in 1965. But times have changed. Public opinion has changed.

In the light of our present experience, not only wtih Medicare, but with Medicaid, and with a multitude of private health insurance schemes, the public is now convinced that there must be some major alterations in our health care system.

The demands of the public in the 1970s in this respect are just the reverse of what they were in the early 1960s. This change in attitude has been prompted by such factors as inflationary increases in the cost of health care, fragmented health care delivery, and uncoordinated development of health facilities.

National Health Security would provide integrated, nationwide reform on the health care delivery system. Health Security would not scrap the existing system, as has been charged. It would, however, transform the present delivery system from one dedicated to the financial interests of health care providers to one dedicated to meeting the health needs of the consumer.

In other words, Health Security would give the American people confidence that their health care dollar buys a dollar's worth of health care.

Unlike most other proposals, the Kennedy-Corman bill would establish a special fund, a Health Resources Development Fund, set aside to provide financial incentives for the system to reform itself.

Before benefits started, the Fund would begin to have an impact on three crucial areas—availability of manpower, distribution of services, and the system of delivery.

Funds would be used both to expand the productivity of physicians and to provide a comprehensive range of services by training additional health personnel, especially primary care physicians, paraprofessionals, and allied health workers.

The problem of the maldistribution of health manpower and facilities would be attacked on both fronts. Special financial "rewards" would be used to attract needed personnel to practice in such health-short areas as inner cities and small towns as well as to issue grants for upgrading health facilities in these areas.

In addition, Health Security would provide support for demonstrations and development of promising methods of organizing health services, such as prepaid group practice, expanded outpatient services, alternatives to institutionalization, and sharing of services among health institutions.

Essentially the Fund would be used for the development of services to meet the changing needs of people in the most effective and efficient manner, not merely to build on already overburdened and often wastefully expensive services. This Fund, in addition to the assured purchasing power of a national health program, would help to overcome many of the present barriers to a balanced and coordinated health care delivery system.

In contrast, H.R. 10028, the Long-Ribicoff-Waggonner bill, has virtually no provisions to reform the health care delivery system. Almost as an afterthought, the bill contains a provision to encourage philanthropic support for changes in the health care delivery system—a provision that is clearly inadequate. Nowhere does the bill commit the public funds necessary for such reform.

The only real answer which the Catastrophic Insurance bill gives to the problem of reform is to leave regulation of the medical industry in the hands of those who presently regulate it—the medical providers and the insurance carriers. The fragmented nature of the Long-Ribicoff-Waggonner proposal would perpetuate the present waste and misallocation of our health care resources.

It provides neither the structure nor the incentives for reform. It suffers from the basic limitations of the insurance approach to health care, because it has no means to deal directly with people's actual health needs.

3. COST AND QUALITY CONTROLS

One of the most important lessons we should have learned from eight years of Medicare is that national health care must be more than a bill-paying mechanism. It is largely self-defeating to make payments to health care providers without demanding quality and efficiency in return. Pouring money into the present health system without controls simply results in inflationary increases in charges and overloads health care providers.

National standards for both individal and institutional providers are needed to upgrade the quality of care, encourage efficient use of manpower, and promote rational planning of facilities.

Qualified health professionals should be reimbursed for services on the basis of established fee schedules, with no billing to the patient. Institutional providers should be paid on a prospective budget basis. The fee schedules and budgets should be negotiated at the local levels by representatives of consumers, health care providers, and the administering agency.

We believe the reimbursement to physicians should be adequate and even generous, considering the value of the services performed and the investment in education that physicians have made. But we do not believe they should be exorbitant or unreasonable as so many of the charges now are.

Under such an arrangement, doctors would know the rates under which they are to be paid for their services. Beneficiaries would know exactly what was covered under the program and the many inequities and causes of confusion existing in the present program would be removed.

National Health Security provides health care with the cost controls of provider reimbursement being made on the basis of negotiated fee schedules and prospective budgeting.

In addition, it establishes a Quality Control Commission, national quality standards for participating providers, and requirements for professional continuing education. A notable example of quality controls is the requirement that covered surgeries be performed by surgeons who are certified by their medical specialty boards.

But National Health Security goes beyond these essential controls by providing health care protection directly to the consumer at the lowest cost, with no waste of the health dollars on parasitic "middlemen," the private insurance carriers.

One of the major arguments given by the supporters of the Catastrophic Insurance bill is that it is less costly than other national health insurance proposals. Such arguments, however, are defective because they include only the costs to be met from public funds and fail to include the total cost met from all sources. When the Catastrophic Insurance bill is examined in the context of total medical costs, it shows no promise of controlling these costs and it may even cause them to increase more rapidly.

The Long-Ribicoff-Waggonner bill does not go beyond the cost-control provisions currently in Medicare. It continues the archaic fee-for-service system without substantial modification. It retains the use of private insurance companies as fiscal intermediaries in the publically financed portion of the bill, and it grants these firms a wide scope of operation in the privately financed provisions. Yet, the private health insurance industry has traditionally shown far greater interest in wealth than health.

Health insurance companies, including Blue Cross and Blue Shield, have done little to bring about coordination of health services, improved quality, or greater efficiency. Instead, they have played a passive function, being middlemen (with a "cut off the top," of course,) between patients and providers.

The history of commercial insurance in the health field began as early as 1908 in state Workmen's Compensation laws. It has continued through the era of negotiated health and welfare plans. Anyone acquainted with this history knows that commercial insurance has been a major barrier to positive health planning and, despite the massive PR campaign, the "Blues" are little better than the commercial insurers who are admittedly in the business for profit.

It is easy to talk about a pluralistic approach to the problem and about building on the "existing foundations" of our present system of commercial health insurance; but this is an unsound and futile approach. What is supposedly one of the pillars of the existing health system is in fact the shakiest part of the whole structure.

Particularly alarming in the catastrophic approach is the incentive which this plan gives to medical providers to push medical expenses above the catastrophic deductible level. As a patient's expenses approach the 60-day and/or $2,000 medical expenses level, medical providers will be encouraged to push these expenses well into the range of catastrophic coverage, especially if the patient's coverage for expenses below the catastrophic level is not fully comprehensive.

Deductible and copayments will be used in both the medical assistance plan and in the voluntary certification insurance program. Under the latter, patients will be liable to a $100 deductible for hospital services and to a copayment of 20 per cent for medical services. Especially objectionable to us is a special copayment requirement under the medical assistance plan whereby a patient who is not a member of a family, must pay all of his or her monthly income, except $50, after the sixtieth continuous day spent in a long-term facility. This provision is, of course, aimed at the poor elderly; and it would have a most humilitating effect on them, besides being a real barrier to care.

Another serious defect in the Long-Ribicoff-Waggonner bill is that it would require providers and practitioners to accept the fee schedule (or "assignment") as full payment only for persons covered under the medical assistance portion of the bill. There is no mandatory assignment under either the catastrophic provisions or under the voluntary certification program. Under these circumstances, many providers could be expected to decline to treat persons under the medical assistance plan, since they would be free to charge other patients more, even though the patient and not his insurance might have to pay the excess beyond a "reasonable cost" determination. This approach would inevitably establish different levels of medical care. A fee schedule is equitable only if it is negotiated in concert with consumers and if it is applied uniformly—not just to the poor and the elderly.

In fact, the lack of any mandatory cost controls in the catastrophic and voluntary certification programs of H.R. 10028 means that persons have no real assurance that their protection under these programs will meet their expenses. Providers remain essentially free to charge whatever they think they can get, there is no way to force providers to conform to "reasonable cost" standards, and the patients themselves will undoubtedly have to make up the difference out of their own pockets whenever the actual charges exceed those deemed to be "reasonable" by the carriers.

There is a basic unsoundness in the heavy reliance, by the Catastrophic Insurance bill, on the physician-controlled Professional Standards Review Organizations (PSROs) for quality control. As presently charged, PSROs are not involved with questions concerning the reasonableness of charges or quality of care. Instead, the area of responsibility for PSROs is to determine whether institutional services are medically necessary and in accordance with professional standards. There is already difficulty in getting the medical profession to participate in PSROs. The limited cooperation that has been secured results from the tacit agreement that PSROs will not become involved in the whole issue of reimbursement. It is, therefore, extremely unlikely that PSROs could be the appropriate organization for a quality control effort.

4. CONSUMER REPRESENTATION

The National Council believes that public accountability, so lacking today, should be assured through consumer representation at all levels of program administration.

The countless pleas we receive from our members on this score were concisely summed up by Dr. S. J. Axelrod, noted University of Michigan health economist, before the Senate Special Committee on Aging as part of their "Economics of Aging" hearings during the last Congress. "I would say," said Dr. Axelrod, "that our American medical care system is characterized by the fact that there is no identifiable point of public accountability. To whom can the older patient go and say 'I don't like what is going on: who is going to do something about it?' "

Health Security would provide a significant role for consumers at all levels of the development and administration of the nation's health care delivery. It would establish a local office in each community charged with responsibility for serving as the "ombudsman" for the consumer. For too long these decisions have been made by doctors, hospital administrators, and insurance company executives. It is time the people had an opportunity to say what they needed and how it should be provided. We have allowed the system to operate primarily for the advantage of those who provide the services, rather than for the benefit of those who receive the services. Yet, it is the consumer who has the greatest stake in the quality of the health system.

The Catastrophic Health Insurance bill contains no substantive commitment to reform the nation's health care system. Consumers would have no direct voice at any point in the new program.

5. SOCIAL INSURANCE ADMINISTRATION AND FINANCING

There is no way that the American people can escape sharing in the costs of health care. But there are essential differences in the way in which they share.

The National Council believes that the cost of our nation's health care system should be prepaid through social insurance, spread broadly and equitably through payroll taxes and general revenues. Insurance, whether private insurance or social insurance, should be designed to protect the great majority of the covered population against the most common risk, not just the exceptional cases.

In addition, health benefits should be administered directly through the social insurance health plan without waste of valuable health dollars on the private insurance industry, whether as fiscal intermediaries—a role they have performed poorly under Medicare—or as underwriters—a role now costing the public billions in high profits and operating expenses.

The National Council of Senior Citizens has long led the fight for adequate protection against medical costs that plague so many of our low-income elderly. But we want this protection through an expanded social insurance system that respects the dignity of the individual without subjecting him to an income test.

Health Security conforms to all of these requirements and concepts of social insurance. It would be financed by the proven and accepted method of social security contributions, matched by general revenue funds, with proper and essential government control over the expenditure of funds. While this would mean a greater tax burden, it would virtually eliminate all other medical costs to the consumer.

The Catastrophic Health Insurance bill departs from these standards in several important ways. The heart of this measure, the catastrophic provisions, dilutes the principle of entitlement by splitting the population to be insured into two basic groups: the steadily employed, on the one hand, and the unemployed, the poor, and the elderly, on the other hand. It is only a short step from this situation to the imposition of a means test as a requirement for coverage under the publically financed catastrophic insurance.

The second part of this bill, the medical assistance plan, actually does impose a means test. Thus, it would substitute the principle of welfare for the sound and proven principle of social insurance with entitlement as a right based on contributions made during the beneficiary's working years.

The voluntary certified insurance policies rest upon a person's condition of employment and/or financial status. If a person becomes unemployed, or suffers a financial set-back, his only recourse is to fall back on the medical assistance plan, essentially a welfare program.

The Catastrophic Insurance bill is a program whereby the private insurance companies can get the federal treasury to bankroll the high risk policies, "clunkers" in the insurance industry's terminology, keeping the low-risk policies to themselves. This bill is certainly not inconsistent with the insurance industry practice known as "skimming." Under this bill, the industry would sell insurance to profitable employed groups, leaving the poor, the unemployed, and other unprofitable high-risk groups and individuals to the governmentally financed part of the program.

Our great fear is that any health insurance proposal that places a heavy reliance upon private insurance companies will be extremely exploitive of the elderly poor and of other disadvantaged groups. This has been the insurance companies' record in the past, and we have seen nothing to indicate that their motives or practices will spontaneously change for the better.

No national health plan is going to be able to roll back medical costs to what they have been in the past. But under National Health Security, an efficiently administered plan can keep costs to a minimum, cut the waste and apply the savings to purchase health care. and do so in an equitable and dignified manner.

6. COMPREHENSIVE BENEFITS

We seek a full range of services for both the acutely and chronically ill to be delivered in a coordinated manner. The scope of benefits should encompass mental as well as physical health. Preventive services should be provided for both adults and children. Care of eyes, ears, teeth, and feet should be included as well as coverage of eyeglasses, hearing aids, dentures, and prosthetic devices.

There should be no limits in the duration of hospital coverage and eligibility for extended care and skilled nursing facilities should not depend on prior hospitalization. Provisions for institutional long-term care for the elderly and other chronically ill persons should be coordinated with a broad range of home health and homemaker's services as well as programs of day hospitals that often make it possible for the infirm individual to live in his own home or the home of relatives instead of an institution.

National Health Security provides for more comprehensive benefits and more complete benefit coverage than any of the other national health insurance schemes. Benefits cover the entire range of personal health care services, especially prevention and early detection of disease. There are no deductibles, coinsurance, waiting periods, maximums, or cutoff dates for the coverage services of physician care, in-patient and out-patient hospital care, home health services, and supportive services such as optometry, podiatry, medical devices and appliances. There are some limitations for adult dental care, psychiatric care, long-term nursing home care and drugs.

The attention which the Kennedy-Corman bill devotes to preventive and custodial care is, unfortunately, not found in the Long-Ribicoff-Waggonner proposal. The latter measure retains the emphasis on acute care which is characteristic of the insurance approach to health care.

The catastrophic part of the proposal merely takes up and continues the same kinds of benefits as currently provided under Parts A and B of Medicare. Benefits excluded from Medicare would also be excluded from this program, except for certain changes in the limits on in-patient and out-patient mental health services. One definite improvement is that there would be no upper limitation on hospital days or home health visits, as there are now under Medicare.

Nonetheless, very little is done to improve or expand the current benefit structure of Medicare, which will remain the basic protection for most of the elderly under this bill. It is below the catastrophic threshold where most of the medical expenses of the elderly will be incurred, and where most of the services for them will be required. Elderly patients would still be faced with high deductible charges and copayments—higher yet if the Administration has its way. All of the shortcomings of Medicare would be left virtually untouched. Overlooked are those benefits which should be included in a program of preventive care, such as eye examinations, payment for out-of-pocket hospital drugs, and care of the ears and of the feet.

We are concerned, also, about the certification program for private health insurance policies contained in Title III of the bill. The requirements which policies must meet to be granted the special emblem of approval are, in our view, neither broad enough nor explicit enough. A special snare lies in the limits on deductibles and copayments which relates them to "reasonable" costs. There is absolutely no assurance that persons insured under a certified policy would not face the same dilemma which faces innumerable persons under Medicare, namely, the refusal of so many physicians and providers to accept the stipulated "reasonable charges" as final and full payment for services rendered by them.

Moreover, we believe that certification of these private health insurance policies could well restrict further expansion of the scope of benefits. Once a private carrier is awarded the emblem of approval for its policy, the carrier has little incentive to improve that policy. After all, the carrier would have a powerful advertising advantage in the emblem itself, and could expect to attract many policy holders on the strength of the emblem alone, without having to improve or to expand the range of benefits beyond the minimum standards in order to attract policy holders.

Right here let me emphasize a basic fact which underlies this entire discussion, a fact that I am sure is well understood by members of this Committee, but which has been thoroughly obfuscated in the public discussion of national health insurance proposals. That fact is that it the American people who are going to pay out of their own pockets the costs of medical care and service which now run to nearly ten per cent of our gross national product. To claim, therefore, as the supporters of the Long-Ribicoff-Waggonner bill claim, that the "cost" of their program is only about nine billion dollars and to contrast this figure with seventy or eighty billion dollars which, according to their estimates, would be the cost of Health Security, is complete sophistry. In the unhappy event that the Catastrophic bill were ever to become law, who would pay the remainder of the total health bill—who indeed, but the American people?

The issue is not how many dollars are to be added to the consolidated budget by the inauguration of a comprehensive health program. The issue is how best to collect and to channel the dollars necessary to provide a good health program. In fact, it is not only conceivable but very likely that a seventy billion dollar Health Security program would actually cost the American people less than a nine or ten billion dollar "bargain-basement" program designed to pay only a fraction of the total of all the charges for health care, leaving the balance to be paid by deductibles and copayments and through wasteful and inefficient commercial insurance carriers whose premiums would, of course, include the cost of advertising, sales commissions, profits, "retentions," and all the other gimmicks known to the insurance industry.

REFORMS IN MEDICARE AND MEDICAID PROGRAMS

Despite the full and complete support of the National Council of Senior Citizens for the enactment of National Health Security, we are aware that present political conditions are not propitious for passage of this legislation. We remain unshaken in our belief that National Health Security must come, that it is the only program that can resolve our health care crisis adequately. But because we recognize that the enactment of this measure is not imminent, we strongly urge this Subcommittee to support, and the Congress to enact, immediate reforms in the Medicare and Medicaid programs which can ameliorate the health care problems among our elderly until we have National Health Security. We, therefore, offer for your consideration, the essentials of a reformed Medicare-Medicaid system which—if it does not actually pave the way for National Health Security—would at least correspond to basic points of that program.

In essence our plan would merge Medicare-Medicaid in a federally administered program covering all residents 65 and older, all other social security beneficiaries, and the adult categories receiving cash assistance under the Supplemental Security Income program. Part A and Part B of Medicare should be combined thereby eliminating the premium for Part B.

Benefits now provided under Medicare would be expanded and payable without coinsurance or deductibles. In-patient hospital services—regardless of prior hospitalization—would be covered for up to 120 days and without limit if they are furnished in a nursing home owned by or affiliated with a hospital, or in a comprehensive health service organization. All out-patient prescribed drugs would be covered if they are furnished through an approved health service organization; otherwise coverage would be limited to drugs needed for maintenance therapy or to especially costly drug therapy. Also included would be care of the eyes (including the cost of eyeglasses), care of the ears, and care of feet.

We firmly believe that the time has come in the Medicare program to move beyond the complicated and confusing procedure now involved in determining "reasonable charges" charges on an individual doctor-by-doctor basis. In place of the present procedure we believe that doctors should be reimbursed on the basis of established fee schedules. All direct billing of patients should be eliminated. The fee schedules should be negotiated region by region or service area by service area. They should represent fair and adequate compensation to doctors. Both representatives of the beneficiaries and the medical profession as well as the government agency would participate in the negotiations in which the fee schedules were established. Those doctors who did not wish to participate in the program could withdraw entirely. Lists of participating physicians should be made public, and doctors should be required to inform patients who are eligible for Medicare as to whether or not they are participating.

Under such an arrangement doctors would know the rates under which they were to be paid for their services. Beneficiaries would know exactly what was covered under the program and the many inequities and causes of confusion existing in the present program would be removed. Elimination of direct billing to patients would especially be helpful in ending the bewilderment—not to mention the out-of-pocket expenses—that beneficiaries so often face when they receive a bill in excess of charges deemed "reasonable" under the present system.

Such a program, we know, will be an expensive one, concentrating as it does on the high risk groups. Without knowing the exact size of the price tag, we nonetheless believe that certain financing principles can be agreed upon at the start.

Federal general revenues should finance 100 per cent of the costs for beneficiaries other than those eligible for social security benefits. As I indicated earlier, the premiums presently charged under Part B of Medicare would be ended, so that social security beneficiaries will no longer have to pay any premiums from their meager retirement income. Some portion of the cost of their coverage should be borne out of general revenues with the remainder financed by a payroll tax. The payroll tax should be the same for employers and employees.

The need for these changes in Medicare (and in Medicaid) is especially great in view of the latest wave of cost increases to Medicare beneficiaries proposed by the Ford Administration. As the members of this Subcommittee know, the Social Security Administration (undoubtedly at the direction of sources high in the Ford Administration) has announced that, effective the first of next year, the present $92 deductible charge under Part A will be increased to $104 for the first 60-day period of hospitalization. There are also proposed increases in copayments.

We regard these proposed changes as another attempt—the last in a long series by the Nixon-Ford Administration—to subvert the very purpose of the Medicare program. We believe that action on the proposals which I have just made would be the most appropriate response that the Congress could make to this latest effort to force poor, sick, elderly persons to bear even more of the high costs of medical treatment.

At this time I should like to take the opportunity to state precisely and explicitly why the National Council of Senior Citizens cannot support a measure boldly entitled "The Comprehensive Medicare Reform Act," introduced as H.R. 1939 in the House last January, and—in slightly modified form—as S. 1456 in the Senate last April. This bill purports to broaden and improve the present Medicare program by making some of the reforms which I have referred to. It does include a list of benefits and it does eliminate copayments and coinsurance for certain groups. It claims to provide health care for all the aged "as a matter of entitlement." This brave claim, however, is substantially contradicted by inclusion within the bill of income tests which would divide the elderly population into "classes" which would be the basis for determining the nature and degree of their entitlement.

Reduced to its essentials and stripped of its rhetoric, this bill would establish a two-headed health insurance system with wide latitude for the operation of private profit-making health insurance. Those deemed to have enough income would pay premiums to the insurance industry. For those so poor that they offer no prospect of exploitation, the government would provide health care benefits, paid for out of general revenues. No wonder the proposal has the endorsement, as stated by its Senate sponsor, of senior citizens organizations which are heavily subsidized by a commercial health insurance carrier.

We reiterate our belief that a genuine reform of Medicare is needed immediately, and that such reform should follow the guidelines which I have proposed. Nothing short of National Health Security for the total population, however, can have the financial leverage to restructure the nation's health care system

HOME HEALTH CARE AS AN ALTERNATIVE TO INSTITUTIONALIZATION

As I have said, the National Council of Senior Citizens believes that optimum health care for the elderly can be achieved only if fully integrated with care for our population of all ages. Nevertheless, we are fully aware of the necessity of directing special attention to the extraordinary health needs of the aged because of the framework in which their illnesses occur—inadequate income, forced retirement with loss of identity, poor housing, lack of mobility, and social isolation.

With these considerations in mind, we should like to extend our testimony to include our views on the important subject of home health care. For the last several years, the phrase "alternatives to institutionalization" has served as the catch-all for issues and areas of interest related to the inappropriate uses and high costs of nursing home, or institutional care. The National Council of Senior Citizens has consistently maintained that there must be a broader and more comprehensive federal response to the needs of older people who no longer have the capacity to live entirely independently in their own homes. Too often, older people who might require limited, and far less costly support in order to remain in the familiar and comfortable surroundings of their own homes, are relegated to spend the rest of their lives in an institutional setting. Why? Because the current Medicare and Medicaid programs actually militate against a less costly solution to meet these limited needs.

It is a sad commentary on our current lack of responsiveness to the health needs of our senior citizens that nursing home or other institutional care often is arranged despite the individuals preference to remain in the community. The inappropriate use of institutional placement for minimal care is largely attributable to three factors:

(1) The incompleteness of the health service structure for providing maintenance care in the community for those elderly and disabled adults in need of this type of home care service;

(2) The prohibitive costs to the individual and/or the family even where such services currently do exist; and

(3) The relative ease of arranging public payment for institutional care in contrast to the difficulty of obtaining public funds to finance necessary home care services on a continuing basis to people outside of institutions even if the costs for home care are less than for institutional care.

Various studies conducted to assess the health and medical needs of current nursing home residents have suggested that on any given day, proportions ranging from 14 per cent to 40 per cent of these residents do not require the level of care for which the nursing homes are being reimbursed by Medicare or Medicaid funds. The variations in estimated "overcare" reflect the results of several different research studies using somewhat different methodologies. However, let us be conservative and take the lowest proportion, 14 per cent. Let us also accept the often stated, but also unproved, argument that with few exceptions current nursing home residents quickly assume the nursing home syndrome and cannot be successfully rehabilitated to return to their own homes.

Nonetheless, we still could say with assurance that if there was an appropriate continuum of care available to them, at reasonable cost, at least 14 per cent of the people who might in the future be placed in an institutional setting could receive appropriate home care services in the community and, therefore, could remain in their own homes.

In dollar terms, the cost of this type of over-care suggests that many millions of public dollars are being misdirected and could be utilized more effectively. In human terms, the costs of institutional overcare are incalculable.

There are currently two major pieces of legislation being considered by the House Committees on Ways and Means and Interstate and Foreign Commerce which address themselves directly to the issues of federally-supported home care and community maintenance programs. H.R. 9829, introduced by Congressman Edward I. Koch (D., N.Y.) is called the National Home Health Care Act of 1975. H.R. 1354, introduced by Congressman Claude Pepper (D., Fla.), is cited as the Medicare Long-Term Care Act of 1975.

Both bills propose changes in the present Social Security Act in order to broaden coverage for home health services so that unnecessary institutionalization and over-care would be less likely to occur. Congressman Koch's bill would remove the current arbitrary limitation of 100 home health visits, as well as expand home health services covered under Medicare by adding homemaker and other correlative services such as chore services, shopping, transportation to and from doctors' offices and senior centers, physical therapy, etc.

Under H.R. 9829, a Medicare or Medicaid beneficiary can qualify for home health benefit if the cost of those benefits provided in the home does not exceed what the cost would be if the individual were to receive skilled nursing facility care. The Koch bill further requires that states include the full range of both medical and correlative home health service in order to qualify for federal Medicaid funds.

The Pepper bill goes a step further by proposing the establishment of community long-term care centers which would provide a linkage for developing and implementing a system of coordinated health and other services for Medicare beneficiaries. The long-term care center would evaluate and certify service needs and determine the level and type of care to be provided, as well as where it can most effectively be provided. The orientation of the evaluation and service plan team would be to try to maintain the individual in an independent living arrangement.

The benefits provided to an individual through the long-term; care center will include: home health services, homemaker and nutrition services, day care, foster home and community mental health center outpatient services, and, when it is appropriate, long-term institutional care services. The long-term care centers would be administered by a governing board comprised of a minimum of 50 per cent membership from persons eligible to participate and receive the benefits of the long-term care center program.

Both bills are based on the assumption that the costs involved in providing community home care services, where such services are appropriate in place of unnecessary institutionalization, will not be greater than costs for benefits currently being expended. The National Council of Senior Citizens wholeheartedly supports these efforts to provide a continuum of care for older people and to make options available to people in need of health and other related maintenance and support services, so that they are not unnecessarily or prematurely placed in an institutional setting.

CONCLUSION

Mr. Chairman and Members of the Subcommittee, we at the National Council of Senior Citizens gratefully acknowledge the care and diligence with which you—as well as the other Members of the full Committee—have compiled knowledge on the topic of national health insurance. We know that full and systematic knowledge must be acquired on this topic before we can embark upon a program of national health insurance with any hope that it will be successful.

But in this, as in any other political matter, *knowledge* alone is insufficient. Eventually those with the responsibility must take action to bring a program of national health insurance into being. In the coming months our membership will be watching closely the action which the Congress takes on this issue.

Mr. Chairman and Members of the Subcommittee, let me thank you for this gracious opportunity to appear today and present our position in favor of National Health Security. Again, I want to express our appreciation for the persistent attention which you have given to this crucial national issue.

Mr. Rostenkowski. Thank you, Mr. Cruikshank.

Why is it, Mr. Cruikshank, that in the polls taken on the relative importance of certain priorities in government, national health insurance isn't really one of the top priorities?

Mr. Cruikshank. I think it is because other very pressing things have come into public view. National health insurance was a top priority until we got into this recession. When you think of a person who is out of work, has been out of work for several months, 6 months or now with the extensions that this committee and others have provided, an extension of unemployment insurance to a year and he is facing the end of that time when he will have anything, and he doesn't know whether the plan will ever reopen or not, you ask him what his primary concern is, I think it is very natural that his primary concern is going to be the loss of jobs and inflation and those economic things that have hit him so hard in the past 4 or 5 years.

Mr. Rostenkowski. Well, I should think that particularly when unemployment compensation runs out and he has lost whatever coverage he had even under private insurance, that health insurance should be one of the first and most important things that he thinks about.

I agree that jobs are the most important thing that we are all discussing today. But close to that is the possibility of illness in the family. And by not having that coverage that they enjoyed while working, a worker's family can be in a catastrophic situation. Thus, it surprises me, since, as members of the Subcommittee on Health, while we are approached frequently with respect to when we think we will get a bill out, the polls taken show that national health insurance has not been a real priority item. That might be, too, because the administration has not looked favorably at it in some time.

They are worried about the budget restraints, of course.

But I noted that you have been discussing national health insurance since Mr. Dingell was in Congress.

Mr. Cruikshank. That is right.

Mr. Rostenkowski. I just think that we are going to have to work in this committee and coordinate our efforts with the Subcommittee on Health of the Interstate and Foreign Commerce Committee and work something out. I think that the time has come for this idea to be adopted by the Congress and I am just hoping that we can do it.

Mr. Cruikshank. I am glad to hear you say that, and we are very hopeful, too. If it is an incremental approach, Mr. Chairman, we would very much hope that the steps be taken in the right direction. I think something like the Long-Ribicoff-Waggonner bill has been described as a step forward, but we think really it is a step backward. There are incremental approaches that can be undertaken. For example, we could start a comprehensive complete care program for children and add periodic years of coverage as the population grows older. That would not be costly, it would give us experience. We could approach it in that way. If it must be an incremental approach, take the little steps for little feet, but in the right direction.

Mr. ROSTENKOWSKI. Well, thank you very much, Mr. Cruikshank. You are always a help in any testimony that you have given before all of our committees.

Mr. CRUIKSHANK. Thank you.

Mr. ROSTENKOWSKI. Mr. Brickfield and Mr. Lane. If you gentlemen will identify yourselves, you may proceed with your testimony.

STATEMENT OF CYRIL F. BRICKFIELD, COUNSEL, NATIONAL RETIRED TEACHERS ASSOCIATION AND AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY LAURENCE F. LANE AND PETER HUGHES

Mr. BRICKFIELD. Thank you, Mr. Chairman.

I am Cyril F. Brickfield, legal counsel for the American Association of Retired Persons and the National Retired Teachers Association.

These are affiliated organizations, Mr. Chairman, and have a combined membership today of 8.7 million people. I am accompanied today on my left by Mr. Peter Hughes, and on my right, Mr. Larry Lane. They are both associates of mine working in legislative matters.

Mr. Chairman, I have two documents here today. I have one that is quite lengthy and the other is 11 or 12 pages, and if you prefer, I would submit both of them for the record to be printed and then I would make some oral remarks.

Mr. ROSTENKOWSKI. Without objection so ordered.

Mr. BRICKFIELD. Thank you.

We seek here today, Mr. Chairman, action on medical health care in this Congress, this year.

How are you, Mr. Corman? It is good seeing you again. You were with us in Seattle in the State of Washington not too long ago.

Mr. CORMAN [presiding]. If I were discouraged that the world problems could not be solved, when I met with that group of enthusiastic mature people and saw their faith, my own was refueled. It was a great experience for me to be with you up there.

I hope you understand the reason for the small attendance. We are passing the baton back and forth to go and vote and keep the committee going at the same time.

Please proceed.

Mr. BRICKFIELD. As I said, to Mr. Rostenkowski, I am submitting both of our printed statements for the record and I will proceed to summarize what I think the high points of my testimony are.

First of all while we support national health legislation we here today seek immediate action on medical health care amendments and in this session of the Congress. First things first. We would like to see something accomplished this year.

We would like to see some augmentation of medical services for the elderly, through medicare and medicaid for the elderly.

Second, we think there is needed a new or revised system of payment procedures to restrain runaway rising health care costs. Now, as I say, our association's national policy is for a national health bill because we believe in comprehensive health care for all Americans, regardless of age and regardless of ability to pay.

However, there have been continual delays in the Congress. We have been talking about national health programs in the Congress of the United States for 4 or 5 years now without the enactment of a national health bill.

So in the meantime we need to help the elderly and we need to help them now. The reasons for this are quite clear and quite simple. The elderly are the most hospitalized of any class, any age class. They have the highest health costs, Mr. Corman. The average medical expenses for the elderly today are $1,218 a year, as distinguished from $400 a year for those between 19 and 65 on the average and for those younger, $183 a year.

The elderly need unlimited outpatient services. They certainly need, and I am sure you will agree, intermediate, long-term nursing care. They also need home health services. They need that sometimes in lieu of institutionalized care.

They need dental services, they need out-of-hospital drugs. In many instances many elderly today have to decide between being paupers, taking the pauper's oath and death itself.

For example, a person goes into a hospital under medicare. After that he may go into an acute nursing care home, and that ends. Then what happens?

If he seeks medicaid he must meet a need requirement. Oftentimes because of State requirements, elderly persons either cannot or are unwilling to meet poverty standards. They are too proud perhaps in some instances, or they don't want to sell the house in which they live or they want to keep a few thousand dollars in the bank. So they don't seek medicaid and what happens? They waste away for want of medical care.

This is what is happening with many elderly, Mr. Chairman.

Now the White House Conference on Aging, which was in 1971, made, with great foresight, a tremendous statement. It said we need a national health bill for all ages, the elderly, the middle-aged, the young. But in the meantime while waiting for such a national health bill, we need to develop a complete range of health care benefits for the elderly.

Our organizations went to the University of Pennsylvania's School for Health Economics and had a national health bill developed, and we are happy to say that Senator Ribbicoff 2 years ago and then-Congressman Carey introduced it as the comprehensive Medicare Reform Act of 1974.

In this Congress it was again introduced by Senator Ribicoff—S. 1456—and on the House side by Congressman Matsunaga—H.R. 1939.

We also support the Kennedy-Corman bill on health security. We don't think, however, it is likely to be enacted at this time, because of the high costs involved. We think it is economically unfeasible at the moment. But certainly in its comprehensiveness we support it. The pricetag on it is enormous and this is the deterrent from its becoming enacted into law.

In developing our own health bill we cut out costly deductibles and costly coinsurance payments. What we have in this bill of ours, Mr. Chairman, which Mr. Matsunaga has introduced, is a system of copayments, small minimal copayments. This is where essentially we differ in this area from the Kennedy-Corman bill and I would like to state for the record the reasons why we put in a system of copayments.

First of all, we note that of some 16 or 18 bills that are now in the Congress of the United States only one provides for no copayments and that is the Kennedy-Corman bill.

Second, when we were developing our own comprehensive medicare reform bill, we talked to Senate staff and found a reluctance in the Senate to introduce a bill without copayments. Staff felt that there should be some copayments. It was an economic cost problem and we had a hard time interesting various senatorial offices in the bill without a copayment feature.

Third, we feel that by making threshold payments people will feel that health care is an entitlement, that they will be entitled to this care as a matter of right and not as some welfare benefit.

Then fourth, we have catastrophic and low-income provisions in the bill to take care of those who are really in need, for those who are low income. They pay no copayments at all.

Turning to another area, there is a great need, of course, for cost controls. Hospitals today are not cost conscious. Hospitals—and I think this is most important—are not competitive. Hospitals don't compete. You go to the hospital your doctor sends you to. There is no incentive, Mr. Chairman, to be cost conscious. Hospitals are reimbursed actual costs.

So we support the provisions you find in various bills that provide for prior approval of hospital budgets, that provide for prenegotiated doctors' fees and things of that nature.

Now, of course, while we have taken the initiative by preparing our own bill which has been introduced by Congressman Matsunaga, we also support, Mr. Chairman, several of the other bills that are in this session of the Congress. For example, we support the Conable-Pepper bill on long-term care.

That bill provides alternatives in many instances to institutionalized care.

We support the Waggonner-Long bill on catastrophic care. As I said earlier, we certainly support the Kennedy-Corman bill. However, like many people, we place a high priority on what we call obtainable objectives. Obtainable this year, that is.

So we, therefore, support the Matsunaga bill or the Ribicoff-Matsunaga bill. I was happy to hear the previous witness for the National Council of Senior Citizens say that this year they certainly support an approach which calls for selected amendments to medicare.

If I recall correctly, in their statement to this committee last year they stated they were for health security or nothing. They did not mention the need for immediate medicare reform. They said delay until after the November elections, wait until next year, and next year is this year and, as their statement admits this morning, a national health bill is not imminent.

So we are glad to see that they, too, support a selective approach to improving medicare at this time. Just to bring myself around full circle, our purpose here today is, one, that we do support a national health bill, but, second, we think there should be action this year in this Congress and so we support objectives which are reasonably obtainable.

We feel that the objectives set out in the Matsunaga bill, and also on the Senate side in the Ribicoff bill, are the best approach on which to seek successful action this year.

Thank you, Mr. Chairman.

[The prepared statement and résumé statement follow:]

STATEMENT OF CYRIL F. BRICKFIELD, COUNSEL, NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

SUMMARY

Mr. Chairman, I am Cyril F. Brickfield, Counsel to the National Retired Teachers Association and the American Association of Retired Persons. These two affiliated, nonprofit Associations with a combined membership of over 8.7 million older Americans, are the largest service and advocacy organizations promoting the interests of the elderly. Accompanying me this morning is my associate, Mr. Laurence F. Lane, Legislation Representative for the Associations.

Mr. Chairman, in order to comply with time restraints, I have prepared my testimony in two parts: a short oral statement which I shall read, and a more formal statement which I ask to have submitted for the hearing record. Additionally, inasmuch as we have attempted in both statements not to duplicate previous testimony before this committee, I urge members and staff to review our presentation of June 21, 1974, which is printed in Volume 6, National Health Insurance Hearings before the Committee on Ways and Means, 93rd Congress, 2nd Session, beginning on page 2520.

My remarks this morning shall be brief. Our message is clear: action must be taken by this Congress to augment Medicare to provide for a complete continuum of health services for the aged and disabled and to incorporate a new system of payment procedures designed to restrain health care costs.

At the outset, allow me to make it clear for the record that our Associations are committed to the enactment of a national health plan which guarantees the availability of comprehensive, quality health care to all Americans regardless of age or the ability to pay. We shall work toward this goal with a continuing vigor.

However, we cannot represent the best interest of our members if we accept the continued delays of Congress and the Presidency in achieving progress in reaching this goal. Older Americans cannot afford to wait for the chemistry of socioeconomic and political events to bring health security.

The plan of action which I shall set forth below is by nature incremental. Realistically looking at the state of our nation, prospects for enactment of a comprehensive health program in the immediate future are obscured by fundamental disagreements over the extent of benefits to be provided, the means of delivering those benefits while simultaneously assuring quality controls, the degree of federal involvement, the means of financing and cost sharing, and the mechanism for providing catastrophic protection.

The nation's older citizens, as a class, face the highest incidence of illness and disability and are the least able to pay for adequate health protection. To those who would condemn our incremental approach by advocating all or nothing. we respond that since the all was set, older Americans have paid for inaction. The average amount of direct expense for health care. i.e. out-of-pocket costs to a Medicare recipient, has more than doubled from $206 in 1969 to $415 in 1974. Additionally, Part B Medicare premiums have added over $30 more per year. This compares to a direct payment average of only $117 in Fiscal Year 1974 for persons under age 65.

Our members, as with most Medicare recipients, are being priced out of the health market in spite of existing programs. They face the option of becoming wards of the state by complying with the demeaning pauper's oath requirements of our social welfare system or death.

Public policy must respond to this crisis situation.

Heeding the call of the 1971 White House Conference on Aging that "pending the achievement of a national health plan, the complete range of health care services for the elderly must be provided by expanding the legislation and financing of Medicare," our Associations in cooperation with the staffs of Senator Ribicoff and former Congressman, now Governor, Hugh Carey drafted the Comprehensive Medicare Reform Act in 1974. This Act is a national health plan for the elderly and disabled, reflecting the need for both immediate action on behalf of these citizens and the ultimate enactment of a health security program for all Americans.

The Bill, in addition to preserving present Medicare benefits, would add additionally needed ones, such as intermediate care facility services, dental services, and out-patient drugs.

Present limitations on the duration of inpatient hospital, skilled nursing, and home health care would be abolished.

The Bill would eliminate deductibles and coinsurance under present law and would substitute a system of minimum copayments with respect to the more expensive items of health care. However, these copayments and remaining limitations on benefits would be subject to a catastrophic protection feature under which low income persons would pay nothing and others would pay out-of-pocket amounts related to their income but in no case more than $750 per family per year.

As to cost restraint under the bill, participating institutional providers (hospitals, etc.) would be required to submit annually a budget and schedule of proposed charges based on the "reasonable cost" of efficient delivery of services for approval. Reimbursement would be based on predetermined, approved rates, thereby providing incentives for efficiency and economy.

With respect to licensed professional practitioners (physicians, etc.), payment would be provided in accordance with annually predetermined fee schedules for local areas under which "fair and adequate compensation" would be provided (not to exceed Medicare's "reasonable charges" standard). Finally, a provider would be required to accept the Medicare payment (plus any copayment) as payment in full for services.

While keeping in mind the need for a realistic, cost-conscious approach to improving the present program, this legislation also recognizes that a serious health care problem now exists for the nation's older and disabled citizens.

Senator Ribicoff reintroduced the legislation in the Senate this year as the Comprehensive Medicare Reform Act of 1975; Congressman Matsunaga has led the sponsor list in the House of Representatives. Several technical improvements have been made in the reintroduced legislation. Essentially these improvements are:

(1) Immediate provision of Intermediate Care Facility Coverage: The needs of the chronically ill must be given immediate attention. The legislation which Congressman Carey proposed in the 93rd Congress phased in coverage of the intermediate care benefit to permit the adjustments mandated by PL 92–223 to run their course. Inasmuch as movement to improve the quality of ICF care is well under way through the Medicaid mechanism, the provision for a lead time to phase in the coverage is no longer necessary.

(2) Special Provisions on Payment for Drugs: The Comprehensive Medicare Reform Act of 1975 has been updated to conform to the Department's regulations concerning maximum cost allowance for multiple-source drugs, and additionally, makes state antisubstitution laws inapplicable to multiple-source drug items that are subject to a MAC if the prescription is filled with an item of the same drug entity. These changes are predicated on the need to ensure both quality and cost-consciousness in the dispensing of pharmaceuticals.

(3) Home Health Services: The revised amendments liberalize the reimbursement of home health services by eliminating the requirement for specification of need for skilled nursing care or physical or speech therapy as a condition of entitlement to home health services. Substitute provisions merely require that the physician certify that the patient needs one or more home health services. This liberalization should assist in building home health as a viable alternative to institutionalized nursing care.

(4) Effective Date: The effective date of the act has been changed to conform to the need for an adequate lead time in which to implement the program. The new effective date would be the beginning of Fiscal Year 1978 (October 1, 1977) with the tax provisions slated to take effect the beginning of calendar year 1977.

(5) Tax Changes: In addition to the continued wage tax on employees and employers, self-employment tax, and the use of certain General Revenues as pro-

posed in the measure for consideration by the 93rd Congress, the revised legislation adds a tax on unearned income of individuals subject to the same tax base limits as the wage tax. This proposal eliminates a serious inequity in the present contributory tax mechanism which does not require those who are independently wealthy and living on unearned income to assume any responsibility for contributing toward the health care of the aged and disabled.

Before turning my attention in the remaining minutes to several other measures before the committee, I wish to amplify our Associations' position with respect to two key issues implicit in Comprehensive Medicare Reform Act.

The first relates to the rationale for the imposition of a coinsurance feature adjusted to income within the Medicare program. Given the scope of benefits proposed and the threshold level of catastrophic protection, we accepted the premise that Congress would impose requirements for cost sharing, and therefore, in drafting the Comprehensive Medicare Reform Act we proposed a copayment graduated to income categories and interfaced with the catastrophic threshold.

A recent Brookings' publication, entitled "National Health Insurance, Benefits, Costs and Consequences," observes: ". . . experience with Medicare emphatically suggests that uniform cost-sharing provisions will lead to wide disparities in utilization among income classes but that reduced cost sharing for lower-income people can allow them to adopt patterns of medical care utilization similar to those of middle and upper-income persons with similar health problems."

We would urge the committee that if it must accept some form of cost sharing, the most equitable feature would be one based on an individual's income and tied to the use of services. Premiums, such as imposed under Part B of Medicare, must be eliminated because they drain an already insufficient income. High threshold deductibles are an economic deterrent to care. Given that preventive care is much cheaper than treating a patient who is already ill, it would appear that any charges which tend to discourage initial entry into the medical system would be in conflict with the goals of cost minimization and of assuring needed medical care for the population. The only cost-sharing feature which could be molded to meet the ability-to-pay principle would be a system of minimal copayments. And, given the threshold level proposed in the Comprehensive Medicare Reform Act for catastrophic protection, we help overcome the necessity for sizable out-of-pocket payments or costly supplemental insurance for large segments of Medicare eligibles.

The second issue which I wish to emphasize is the immediate need for congressional action to control health care inflation. The reaction of the health sector to the cost restraints imposed under the 1972 amendments clearly indicates that without increased governmental controls over that sector, the market mechanism will be abused to excess. We, as a nation, can ill afford a health system that is predicated on delivery to the rich while the general public is ignored. We commend to the committee the provisions of the Comprehensive Medicare Reform Act of 1975 as a model for a more responsive reimbursement system.

While our Associations have taken the initiative by assisting in the drafting of health legislation for congressional consideration, we are supportive of a range of additional suggestions contained in other pieces of legislation before the committee. We underscore our commitment to secure affirmative action in this Congress towards alleviating the crisis in health care for the aged.

We commend for serious consideration by this committee the Medicare Long-Term Care Act of 1975 proposed by Congressman Conable and Congressman Pepper. This proposal would establish a new program of long-term care for the elderly that would provide alternatives to institutional care. Under the present program, benefits, limitations and payments for services in long-term care are defined and described according to levels of care needed by the users and the service capacity levels of classes of providers. Congressman Conable's proposal for long-term care benefits could be a major step toward reducing the level of care limitations and definitional problems in the present Medicare and Medicaid programs.

Additionally, the Long-Term Care Act develops a comprehensive delivery system designed to meet not only the curatively acute needs of the elderly but also the equally important health-social service needs of the chronically ill. Our Associations have been working closely with Senator Beall of Maryland on perfecting the mechanics of the Conable-Pepper approach, and we alert the committee to the possible introduction of a revised Medicare Long-Term Care Act within the coming weeks.

While the Catastrophic Health Insurance and Medical Assistance Reform Act falls short of the comprehensive protection needed by the aged and disabled, we view the impact of this legislation as progressive and desirable should the committee feel economic considerations require less than a comprehensive approach. The catastrophic program must be better coordinated with Part A to avoid conflict between the calendar year and Medicare's spell-of-illness concept.

With respect to this bill's federalization of Medicaid, the application of a uniform eligibility standard and benefit package under a federal program for low-income individuals and families is a desirable improvement. Our Associations have long advocated the federalization of the Medicaid program.

As I stated in the introduction to my remarks, our Associations would be supportive of the passage of the Health Security Act; realistically however, we place a higher priority on immediate passage of obtainable objectives by this Congress than on a firm belief in a singular approach. Even with Health Security, our Associations see a requirement for further attention to the long-term care needs of older persons. Additionally, we would urge that greater direction be given to the administrators of the program than the legislation proposes. Our experience since the enactment of PL 92–603 has made us leary of granting broad regulatory writing discretion to the Executive Branch. Finally, we would urge careful review of the definitional terms accepted from the present Medicare program. The Health Security approach is steeped in an acute, curative, medical model, which overlooks the special needs of the chronically ill.

Likewise, we have a favorable evaluation of many of the key features of the National Health Care Services Reorganization and Financing Act but we sense that the sweeping reforms proposed will not be acceptable to this congress. Many of the pitfalls of the Health Security Act apply equally to this legislation.

The Health Care Insurance Act will not benefit the aged at all and may be detrimental. For the non-aged, this bill should initially provide some protection by facilitating the expansion of private health insurance. Without any provision for containment of health sector inflation, however, it appears that this legislation would put gasoline on the fires of inflation. In the long run premium charges would rise, deductible and coinsurance amounts would increase, and the drain of both public and private resources would persist.

With respect to the Administration's Comprehensive Health Insurance Act proposed in the 93rd Congress, which appears from reading the "Forward Plan for Health, Fiscal Year 1977–1981," may be resubmitted in the future, our Associations strongly believe that this measure fails to address itself to the problems of the health care needy and fails to come to grips with the problem of rising health care costs. The entire benefit package, when considered in the context of durational limitations, represents at best a slight expansion of protection which falls far short of the comprehensive protection needed by older Americans. Rather than contain costs, the legislation shifts the burden to the consumer. The establishment of a charge account method for payment of services is the one provision in the legislation which NRTA/AARP does endorse.

In closing, Mr. Chairman. I want to emphasize the need for action now to alleviate the burden of health care costs encountered by the elderly and disdisabled. We must form a consensus behind at least an incremental approach to health care that would expand the scope of present benefits and contain spiraling inflation in the health sector. We must show affirmative action on behalf of those persons who are receiving an average Social Security check of $186 a month and who are shouldering more than 60 percent of their health care costs as a result of the failure of present public policy.

STATEMENT

In the statement which the National Retired Teachers Association and the American Association of Retired Persons submitted to this committee during the 93rd Congress, 2nd Session. we analyzed the impact of the provisions of each major plan upon the elderly and compared the provisions of each bill not only to present law but also to the Comprehensive Medicare Amendments which we hold as a model for action.

We have built upon that framework to offer to the committee this morning a paper which (1) underscores the special needs of older Americans vis-a-vis the health sector. (2) develops a framework from which to measure policy growth toward meeting those special needs, and (3) apply that model to present policy.

As a means of introduction to his classic volume on "Nursing Home and Public Policy," Thomas suggests three factors in causation for the development of nursing homes:

(1) Improvements of the hospital as a curative, remedial facility thus causing a division of labor separating the historic sheltering function.

(2) Increased urbanization caused change in the character of the domestic social structure, the conjugal family, assuming a much greater importance than the extended family.

(3) There has been an increase in the life span.[1]

The precise problem is pinpointed in terms of a continuing need for a policy instrument, or mix of policies, to meet the demands of a broadened lifespan. Capturing the issue, Cherkesky writes:

"The brilliant successes of medical science in the last fifty years have resulted in substantial control of the acute illnesses that have affected our population.

"The life expectancy for the average American has increased roughly thirty years since the turn of the century. Because of this increase, we have an aging population and as a result the crucial medical care problem of our time is chronic illness." [2]

Brotman substantiates the Cherkesky declaration that a large aged population is a rather new phenomenon, new to this century. He points out that the 65+ group is 6½ times as large as in 1900; at the turn of the century there were three million older persons, every 25th American. Today, there are twenty million, every 10th American. The older population is projected to grow to one out of every nine Americans by the year 2000. Brotman further indicates that the oldest part of the older population is growing fastest; the median age of the elderly has risen slowly to age 73. On the older side, 4 out of every 10 older persons, or some eight million, are 75+ and of these, better than a million are 85+. On the younger side, better than one-third, or seven million, are under 70.[3]

HEALTH OF THE ELDERLY

Elwood points out that "growing old is not synonymous with disease. Aging does not mean pathology. Nevertheless, it is an inescapable fact that with the passage of time, there is increased incidence and severity of major diseases." [4]

What is significant writes Dr. Stanley Brody of the University of Pennsylvania is:

"That while 81% of the over 65 population suffer from some chronic illness, 33% have no physical limitation on their activities; 7% have some limitations, but not on their major activities; 26% have limitations on major activities; and about 16% are unable to carry out their major activities. Thus, approximately half of the elderly are somewhat disabled because of a chronic illness." [5]

Shanes and Townsend further confirm the correlation between age and physical disability, stating that 25% of the elderly have major problems of adaptability because of a chronic condition.[6] Of further importance, given the Brotman demographic profile is that the researchers have also found a high correlation between chronic disability and years over 65, i.e., the fastest growing segment of the aging population is also the segment most prone to sever chronic disability.

Mental impairment also imposes limitations of functions, points out Brody. Estimates prepared by researchers indicate that the incidence of mental impairment among the elderly vary from 10% to 25%. Rates of psychosis, symptoms experienced as physical illness and organic mental disorders, as with physical disabilities, rise with advancing age.[7]

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[1] Thomas, William, "Nursing Homes and Public Policy" (Cornell U. Press, Ithaca, N.Y.), 1969. p. xii.

[2] Cherkasky. Martin as cited in *Ibid.*, p. vii.

[3] Brotman, Herman. "On Older Americans"; "Retirement Life," March 1972.

[4] Elwood, Thomas. "Background Notes on Physical and Mental Health Needs of the Aged", Encore Seminar Series Speech, University of Pennsylvania, October 26, 1973.

[5] Brody, Stanley, "Comprehensive Health Care for the Elderly: An Analysis", "The Gerontologist," Winter 1973.

[6] As cited in *Ibid.*

[7] *Ibid.*

ECONOMICS OF THE ELDERLY [8]

The median income of older families and individuals is consistently less than half of that of their younger counterparts. Although recent Social Security increases have had a dramatic impact in reducing poverty for older Americans, the tide on inflation has swept much of the gains away. In 1969, nearly 4.8 million persons 65+ fell below the poverty line; 1973 statistics estimated 2.1 million persons 65+ are below the poverty threshold. Unfortunately, during this time frame when Social Security benefits were substantially raised, the cost-of-living advanced over 25%. The Department of Labor budget statistics for a retired couple (based on 1972 calculations) for the low budget was set at $3,442 a year. This is $118 a year more than the average couple is receiving in Social Security benefits.

There is also a substantial amount of hidden poverty among the elderly. Nearly 2 million aged persons are not classified as poor, simply because they live in families with incomes above the poverty level. If these individuals were also counted, the number of elderly in poverty would soar to almost one out of every three persons 65 or older. Another way to express the income status of the elderly is to point out that although the number of poor is decreasing, the aged poor form a slowly increasing proportion of the total. The aged make up 10 percent of the population by 20 percent of the poor. If you are old, you are twice as likely to be poor.

As might be expected, older people having half the income, spend about half as much as do younger consumers. By the same token, their consumption pattern is different, revealing the interaction between continuing needs and restricted income. Proportionately, older consumers spend more of their income on food, housing, household operations, and medical care than do those under age 65. Paying the cost of purchasing health care for the older population is complicated not only by the fact that their needs increase as their incomes are slashed by retirement, but also by the fact that their needs change to long term care as a result of the prevalance of chronic conditions, disease and impairments.

SOCIO-ENVIRONMENTAL FACTORS [9]

Beyond the health and income characteristics of our target population is a broad area of concern which paramatizes the elderly person's relationship to his or her environment. Four major areas of concern within this defined characteristic include: housing, mobility, social interaction and nutrition.

The elderly pay a disproportionate part of their income for rent and homeownership costs. While those under 65 pay 23 percent of their income for these costs, the aged pay nearly 35 percent. In one mid-western state, more than 8,000 elderly homeowners living on less than $1,000 a year paid 30 percent of their income on real estate taxes alone. While 71 percent of the housing units occupied by elderly heads of households are owner-occupied, 6 million older persons live in dilapidated or substandard housing, 1.6 million live in units lacking basic plumbing facilities and another 5 million live in overcrowded housing conditions.

The 1971 White House Conference on Aging identified the lack of mobility caused by inadequate or inaccessible transportation as the third major concern of older persons (behind insufficient income and poor health care). Studies have indicated that while our society becomes more mobile with each passing year, the elderly becomes less mobile. This transportation crisis not only results in forced isolation of the elderly but also intensifies many other problems. The lack of mobility can result in poor nutrition because of the inaccessibility of food outlets; disassociation, withdrawal and loneliness, because it is difficult to attend church, visit friends or relatives, or participate in other group or community activities; and poor physical and mental health, because it is difficult to visit the doctor's office, community health centers or outpatient clinics.

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[8] All figures cited in this section are extracted from testimony before the Senate Special Committee on Aging inquiry into "Future Directions in Social Security," 93rd Congress, 1st and 2nd Sessions.

[9] This section is predicated on testimony given to the Select Education Committee or the House Education and Labor Committee in hearings on the "Older Americans Act Amendments," 93rd Congress.

As mentioned in the Thomas quotation, there has been a change in the domestic social structure placing greater emphasis on the conjugal family for setting the tone of societal roles. As it relates to the elderly, these roles have two dimensions:

(1) To provide services for older persons.
(2) To provide older persons with opportunities for services.

There is ample evidence documenting a direct relationship between patterns of daily activities and morbidity. There is an equal volume of evidence equating the fear of crime, incidence of crime and social activities of the elderly.

Gold Point Out: "Even if incapacitation does not occur, a narrowed concept of family responsibility for older members cause some older persons to have fewer contacts, a diminished sense of serving as a link between the past and the future, less of a sense that one's accumulated knowledge is worthy of respect and fewer opportunities to perform tasks useful to other members of the family."[10]

There is general agreement in the assessment that most problems of the aged are compounded by poor nutrition. The statement of policy to the National Nutrition Program for the Elderly (P.L. 89–73, as amended) best states the case:

"Many older persons do not eat adequately because (1) they cannot afford to do so; (2) they lack the skills to select and prepare nourishing and well-balanced meals; (3) they have limited mobility which may impair their capacity to shop and cook for themselves; and (4) they have feelings of rejection and loneliness which obliterates the incentive necessary to prepare and eat a meal alone. These and other physciological, social and economic changes that occur with aging result in a pattern of living which causes malnutrition and further physical and mental deterioration."[11]

ASSESSMENT OF SERVICES TO MEET NEEDS

Given the above profile of our target population, we must ask, what taxonomy of services correspond?

Our profile suggest distinct generic need categories corresponding to the health, income maintenance and socio-environmental characteristics. Traditional public policy response has been cast in this mold, providing distinct service response to each generic need category suggested by the profile.

While distinct in many aspects, it is important for purposes of public policy formation to understand the integrated relationship of these need categories. Zelenka has cast these needs in terms of a triangle (diagram 1). Depicted in this manner, one can visually understand the interdependence of the stated needs. Brody gives human form to the dimensions of this relationship when he asked: ". . . should the situation of the 75-year-old lone woman living in an apartment on the second floor of a walk-up be classified as a cardiac or a housing problem? Or, if she is typical of those elderly now subject to the new phenomenon of fear of assault, is she psychologically able to reach medical services via available public transportation?"[12]

Add the dimension of insufficient income and/or chronic disability, and our multi-need interdependencies show sharp correlation.

Recognizing this interdependency, we shall assume as given an adequate government response to the indentified income maintenance and socio-environmental needs. Accepting this broad assumption, we can narrow our discourse to the specific assessment of the health service needs.

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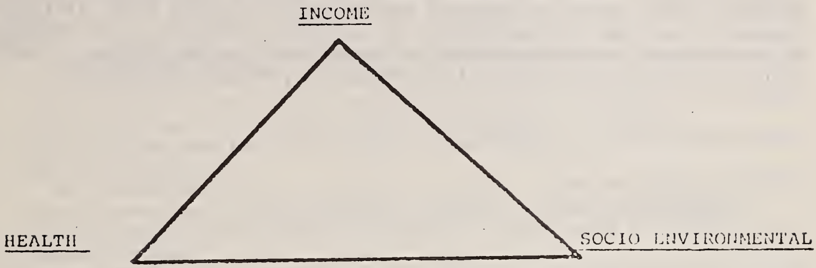
[10] Gold, Byron, "The Role of the Federal Government in the Provision of Social Services to Older Persons", *The Annals*, September 1974.
[11] "Statement of Policy", *Public Law 89–73*, as amended. U.S. Government.
[12] Brody, *op. cit.*

Diagram 1:

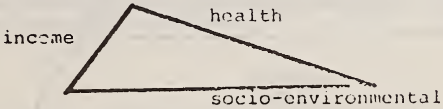
MULTI-NEED INTERDEPENDENCIES·



Source: Zelenka, Frank. "Health and the Elderly" an unpublished presentation before the National Convention of the National Association of Social Workers, May, 1973, Atlantic City, New Jersey.

Special Note:

The Zelenka model can be used to demonstrate that efforts to meet one need may infact intensify other needs.



Extracting from the testimony before the Senate Special Committee on Aging hearings during 1973–74 on barriers to Health Care for older Americans and from the academic writings in the Gerontologist (the journal reporting new developments in the aging field), there appears to be substantial agreement that within the continuum of geriatric health care there are two distinct models of care (1) medical and (2) health-social services.[13]

The medical model meets the acute, episodic needs of the patient. Weiler has characterized the objective for acute care in the following manner: "The objectives for acute care are to help the patient through the acute crisis as speedily as possible. In the process of treating acute illness, all the other needs of the patient become secondary (i.e., social, professional, family). The services, facilities, and resources needed are usually finite. Success is measured in improvement or recovery terms, i.e., the number cured over the number not cured." [14]

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[13] Senate Special Committee on Aging hearings on "Barriers to Health Care for Older Americans," 93rd Congress.

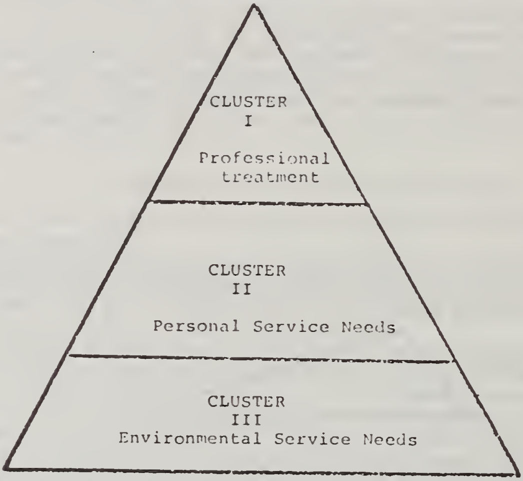
[14] Weiler, Philip, "Cost Effective Analysis, A Quandary for Geriatric Health Care Systems", "The Gerontologist", October, 1974.

The health—social service model places greater emphasis on secondary needs. Instead of a disease orientation, health—social service places emphasis upon the patient's potential to function in the social, professional, and family spheres of his life. Success is measured in terms of actual level of functioning compared to potential level rather than a set textbook utilization review procedure.

The National Council for Homemaker—Home Health Aide Services, Inc. have identified three specific clusters of health—social services needs (diagram) Cluster I constitutes the requirement for professional treatment, the individual is out-of normal balance in physical or mental health, or his physcial or mental health is deteriorating. Cluster II is identified as personal service needs.

Diagram 2:

CLUSTERS OF NEEDS: *



* cumulative

Source: National Council for Homemaker-Home Health Aide Services, Inc., *Costs of Homemaker-Home Health Aide and Alternative Forms of Service*, 1974.

The individual is not in need of regular direct professional treatment, but his age, condition or family are such that he requires help from someone outside the home in bathing, feeding, dressing and so forth. There is an implied vulnerability to physical and social needs. Cluster III identifies the environmental service needs. These involve basically the housekeeping tasks; the provision of a clear decent surrounding and the provision of food and supplies for everyday living necessary for health and survival. The three clusters of need are not clearly exclusive of one another.[15]

MEASUREMENT OF POLICY

Given the above description of our target population and an assessment of their service needs. We must now return to the basic question of how do you meet these needs?

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[15] National Council for Homemaker-Home Health Aide Services, Inc., "Costs of Homemaker-Home Health Aide and Alternative Forms of Service," 1974.

Brody has stated that "any health system which continues to be limited to a disease orientation will not meet the increasing needs of the aging community." He suggest developing health-social services as at least an equal component of our geriatric health system. As he states, this does not imply a denigration of medical care, but rather an elevation of the health social service care profession to equality , visability and recognition.

There are five component parts to the Brody health-social service delivery system:

(1) Personal Services are keyed to personal hygiene including grooming, dressing, and bathing.

(2) Supportive or extended medical services are extensions of the physician's role and performed according to his orders and review.

(3) Maintenance services including housekeeping, environmental hygiene, and food preparation.

(4) Counseling involves listening skillfully, extending help, mobilizing existing resources, and enabling the utilization of these resources.

(5) Linkages are any set of services that help connect the elderly to the needed services.[16]

Note, service set (1) corresponds to needs Cluster II; and service set (3) corresponds to Cluster III. Service sets (4) and (5) provide connections between the health services and the income maintenance and socio-environmental services. This is an explicit recognition of the interdependencies of need categories mentioned above.

Weiler has built upon the Brody framework suggesting that we must develop a "fundamental strategy on health care for the aged along with the long term (health-social services) model. This strategy should state the goals and objectives for long-term care and it should emcompass:

(1) Consideration of the resources needed to provide health care for the aged, with emphasis on alternatives to end prevention of institutional care.

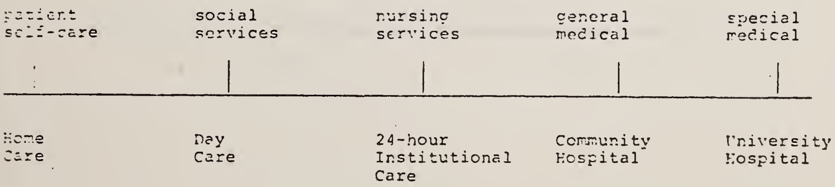
(2) The financing mechanisms for health-care benefits to assure assessibility of care.

(3) The quality of care received, including consumer protection issues.[17]

Providing the continum depicted in diagram 3, Weiler suggest as the federal funding mechanisms required demonstration of cost effectiveness, there will be a shift to the left on the continuum of care.

Diagram 3

WEILER'S CONTINUUM OF CARE



To this point, we have laid a framework based in a survey of the literature. Now we shall depart into uncharted waters, for,—While verbally discussing service development, neither Brody or Weiler offer a realistic tool for measuring policy. The Weiler continuum hopelessly simplifies the complex serious needs and corresponding service development to a point of nonapplicability.

In order to develop a workable measure for policy development, we must construct several plans of government action in geriatric health care. This approach has two outstanding benefits:

(1) We have a yardstick to measure policy growth.

(2) We can recognize the impact of total policy development across a group of activities rather than myopically focusing on singularly incremental policy.

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[16] Brody, *op. cit.*
[17] Weiler, *op. cit.*

To facilitate the development of our analytic framework, several qualifications will be made. First, it will be given that the government has the responsibility and the authority to meet the needs of our target population. Secondly, we accept the Brody-Weiler assessment of geriatric health care as valid. (Empirical evidence overwhelmingly supports this construct). Thirdly, we shall begin on the plain of one single government, i.e., the federal involvement. This assumption will be relaxed at a future point.

Essentially, there are three different levels of program analysis (each of which have several subsets) which must be drawn together to build a unified measure of directions in geriatric health services.

The components to be measured are:

(1) Benefit Incentives
(2) Resource Incentives
(3) Linkage Incentives

BENEFIT INCENTIVES

Four subsets of measurable policy comprise the vectors indicating direction of benefit incentives: Reimbursement, Eligibility, Utilization Review, and Cost Consciousness. (Diagram 4)

Reimbursement policies can be measured on a continuum depicting the benefits made available by the government. The Brody-Weiler continuum resembles the reimbursement continuum in as much as they equate reimbursement as the sole determinant of policy direction. A restricted benefit package would provide coverage for the health-social service model described by Brody.

Eligibility adds a second dimension of benefit incentives which has often been implied by previous writers, but never explicitly placed in the context of measuring the direction of geriatric health policy. Measuring on a continuum from right to left, we can visually categorize the steps of policy that determine eligibility. The far right position documents a means-tested program, where eligibility for benefit reimbursement is predicated on available income and resources. Our scale moves leftward encompassing entitlement based upon eligibility for social insurance programs, combinations of threshold costs, premium payments, and coinsurance features. The far left position reflects nonmeasurement of a person's ability to pay as a determinant of eligibility for care.

Diagram 4

CONTINUA OF BENEFIT INCENTIVES:

Subset A: Reimburement Policies:

liberal benefit package (+) —— (-) restricted benefit package

Subset B: Eligibility Policies:

health care as a right (+) —— (-) health care predicated on income

Subset C: Utilization Review Policies:

flexible (+) —— (-) rigid

Subset D: Cost Responsiveness Policies:

controlled (+) —— (-) free market

Our third measure of benefit incentives considers utilization control factors. Given the specific needs of older persons, experience has shown that the more restrictive the criteria for placement within health institutions, the more restrictive the benefit package. There is a necessity to measure the nature of the present and proposed review procedures to ascertain adequacy. A rightward position on our scale would indicate a rigid utilization review policy which might restrict the access of the elder patient to proper care, while a leftward position measures increased flexibility in criteria.

Related to utilization review is the fourth subset of benefit incentives: cost responsiveness. The erosive effect of health care inflation has threatened the health care benefit structure besides undermining fiscal and budgetary decision-making. There is a necessity to measure the incentives for cost containment within the present and proposed health legislation. Accepting the premise that lack of cost responsiveness will either necessitate the shifting of benefit costs to the consumer of health services and/or reducing the scope of the benefit package, we suggest a continuum be constructed that measures from right to left the incentives for cost containment. The rightward position reflects a free market position, and the leftward position indicates controlled reimbursement policies.

RESOURCE INCENTIVES

Our second parameter of policy direction suggest the necessity to measure quality controls, developmental policies and manpower as separate indices. (diagram 5)

Our quality control continuum measures the relationship of government involvement in the market mechanism to ensure conformance with certain prescribed norms. Governent involvement has often been casted as restricted upon the provider, and, therefore, we have drawn our continuum from right to left indicating provider-oriented as the fair market position and consumer oriented as the optimum quality position. Along this continuum we can measure from right to left provider agreements, physical plant maintenance, licensing of personnel, levels of consumer involvement etc. While it might be unclear to the reader as to why this would be considered a resource incentive, be mindful that underlying the development of the health-social service model is the belief that consumer involvement adds needed patient input toward self-maintenance.

Diagram 5

CONTINUA OF RESOURCE INCENTIVES:

Subset A: Quality Control Policies:

consumer oriented (+) ———————— (-) provider oriented

Subset B: Developmental Policies:

integrated (+) ———————— (-) segregated

Subset C: Manpower Policies:

para-professional (+) ———————— (-) professional

Consideration of developmental policies should further focus the reader's attention to the resource considerations necessary for policy formation. Restricted development practices adhere to an institutional bias. Integrated development practices encourages a flexible and balanced utilization of all available resource potentials.

The third component part of our resource incentive measurement weighs manpower policies.

Our continuum runs right to left indicating a strick professional interpretation as the right-most position and untrained personnel as the left-most position. Along this continuum we can measure geriatric training for specific professionals, training of para-professionals, encouragement and utilization of para-professionals, and involvement of limited trained personnel for specific tasks. For purposes of clarity, it should be understood that this continuum reflects a cumulative use of personnel from right to left.

LINKAGE INCENTIVES

While Brody specifically mentioned linkages as an important component of the health-social service model, neither he nor Weiler adequately built into their continuum a practical measure of these program interdependencies. An attempt will be made to do so in our analysis, measuring accessability, administration and coordination. (diagram 6)

Our continuum of assessability measures availability of health resources to the target population. While reflective of the benefit reimbursement criteria and the resource development criteria mentioned above, assessability must be given independent evaluation as a policy direction. Our continuum stretching from right to left measures the extent of outreach effort. The right position reflects non-encouragement, the left position advocates active encouragement.

The old adage that you can lead a horse to water, but you cannot necessarily make him drink can be applied to our second indice of linkage incentives. A right most position on our administrative complexity continuum can negate positive reflection on all our other scales.

Diagram 6

CONTINUA OF LINKAGE INCENTIVES:

Subset A: Assessability:

encouragement ———————— non-encouragement
(+) (-)

Subset B: Administration:

simplified ———————— entanglement
(+) (-)

Subset C: Coordination:

complementing
design ———————— competing
(+) (-)

The left position of minimal administrative entanglement, while a bureaucrat's nightmare, is considered the patient's dream.

Our final measure accents coordination of the geriatric health plan with ancillary social service programs. For purposes of measurement the right-most position reflects neglect to coordination while the left-most position depicts complementing program design. Clarification is again necessary to indicate that we are using a loose construction of social services to include all other government economic and socio-environmental programs (which we above accepted as operational). Along this continuum we can thus measure information efforts, referral efforts, and follow-through assistance efforts.

It should be apparent to the reader that to the extent that public policy as measured on our ten scales remains on the right side of our continuo, geriatric health care will reflect the acute model with minimal development of the health-social services model. Leftwardness would indicate establishment of health-social services which we have defined as the necessary policy instrument to meet the needs of older Americans. A mix of direction along the ten scales is a clear index of incremental policy which posess the possibility of counter-productive public policy. This situation would appear most crucial where subsets of our three identified levels of analysis are in disoriented direction. Varying positions within the subsets of benefit incentives, resource incentives and linkage incentives suggest that positive direction in one subject might be negated by negative direction in a related subset.

EVALUATION OF PRESENT PROGRAMS

We have asserted to this point that our three levels of policy analysis—benefit incentives, resource incentives, and linkage incentives—and their respective subset scales of measurement are a more reflective indicator of policy direction than that suggested by Brody or Weiler. The test of relevance is in the application.

Foremost in our attempt to apply our model is the fact that no one program spans all ten criteria which we have identified as significant for the development of a comprehensive geriatric health care system. We do have a maze of incremental programs which are separately administered across three plains of government and which can be measured for their policy impact on our scales. This leads to our first observation: We do not have a unified health system.

MEDICARE

During fiscal year 1974, the nation spent about $90.3 billion for personal health care. While constituting 10 percent of the population, the aged accounted for over one-quarter (29.5 percent) of this amount.

The average personal health care outlay for the total population was $420. For the average aged person, it was over $1,218. Medicare met less than two-fifths (38 percent) of the aged health bill. But, at the same time, average out-of-pocket payments for the aged person (not including Part B Medicare premiums) was $483—about three times the amount for persons under age 65.

About 98 percent of all persons over 65. or 23 3 million persons, are eligible for social security cash benefits. These individuals are enrolled automatically in Medicare's Part A hospital insurance program. The remaining 2 percent of the aged may enroll and pay the full premium, which is $40 a month, for the same coverage.

The Social Security Amendments of 1972 extended Medicare coverage to those persons under 65 who have received disability insurance cash benefits for 24 months and to anyone afflicted with end-stage renal disease.

Medicare's Part B program of physician services is available on a voluntary enrollment basis to any person who is either over 65 or who qualifies as a disabled individual.

Part A is financed through a 1.8 percent payroll tax paid equally by employers and employees. Part B is financed 40 percent from premium contributions ($6.70 a month per enrollee in fiscal 1976) and the remainder of the coverage from general revenues.

Applying the theoretical framework which we have developed to the Medicare program, we find the following results:

BENEFIT INCENTIVES

A cumulative review of the four subsets which we have identified as components of the benefit incentive indicates that Medicare is steeped in the medical model, failing to meet the health-social services needs of older persons.

Medicare's benefit package is heavily skewed to the acute model of care. More than nine-tenths ($7.8 billion) of Federal funds for hospital care of the aged came out of Medicare funds in Fiscal Year 1974. Medicare's supplementary medical insurance trust fund financed approximately 52 percent of the elderly's expenditures for physician services in that same fiscal year. Nursing home expenses of the aged are scarcely affected by Medicare. In 1974 only about 3 percent of total costs were covered, compared with a high of 15.8 percent in 1968. This reflects the fact that Medicare pays for skilled nursing services only if it is ordered by a physician and is provided in a skilled nursing facility after a specified hospital stay; time and day limitations and co-payments are also imposed. Likewise, home health services have been seriously curtailed due to strict interpretation of the scope of and eligibility for such services. Medicare does not pay for dental care, out-of-hospital prescribed drugs, and eyeglasses.

Eligibility for Medicare coverage is restricted. Entitlement to coverage under Medicare Part A Hospital Insurance is limited to (1) those individuals aged 65 or over who are entitled to monthly Old Age or Survivor Insurance benefits under Section 202 of Title II of the Social Security Act or is a "qualified railroad retirement beneficiary"; (2) certain transitional entitlements for persons aged 65 or over; (3) persons aged 65 or over who meet the requirements for voluntary enrollment under Part A; (4) individuals under the age of 65 who have been entitled for not less than 23 consecutive months to social security or railroad retirement benefits on the basis of a disability; or (5) to individuals under age 65 and medically determined to have chronic renal disease and to require homodialysis or renal transplantation provided the person is entitled to coverage.

Entitlement to enroll in the Supplementary Medical Insurance program is equally restricted. The individual must (1) be entitled to Hospital Insurance benefits of Part A, or (2) be a person aged 65 or over who is a resident of the United States and is voluntarily enrolled.

Once the test of entitlement is met, there is a restriction of eligibility to reimbursement imposed by cost sharing. Under the Hospital Insurance Program, inpatient hospital services are subject to an inpatient hospital deductible for each spell of illness. The amount of the deductible (presently $92 but to be raised in January 1976 to $104) is determined by the year in which the spell of illness begins. Inpatient hospital services and inpatient skilled nursing services are subject to daily copayments after a prescribed stay. Whole blood or packaged red blood cells received by a beneficiary as part of the service furnished under the Part A program during any spell of illness are subject to a deductible. Coverage under Supplementary Medical Insurance (Part B) is contingent upon the payment of a monthly premium (presently $6.70). In addition, under the Part B program, there is an annual deductible of $60.00 and a 20 percent coinsurance that requires a sharing of expenses above the deductible amount on most services.

Public Law 92-603 established two approaches to the determination of utilization review of health facilities. The first approach required the development of procedures for preadmission approval and periodic review of patient coverage. The second approach developed a more permanent structure of independent professional standards review organizations (PSRO's), formed by organizations representing substantial numbers of practicing physicians in local areas to assume responsibility for the review of services provided through Medicare and Medicaid. While an emphasis has been placed upon encouraging flexibility in the development of review procedures, there is no requirement for consideration of other than medical factors in the review process, and therefore, where practiced, review has been trapped in the medical model of care.

With regard to our fourth criteria, cost responsiveness. we have faced a dilemma in the Medicare program: The program is costing the public more and providing less and less medical protection. In facting this dilemma during consideration of the 1972 amendments, Congress expressed the hope that placing a lid upon accelerating physician fees by requiring that prevailing charge levels used in determining reasonable charges may be increased above the level for fiscal year 1973 only to the extent determined justified by the Secretary of Health, Education, and Welfare. The reaction of the health sector to the costs restraints imposed under the 1972 amendments clearly indicates that without increased government controls over that sector, the market mechanism will be abused to excess.

RESOURCE INCENTIVES

To the extent that present Medicare policies have had an impact upon the subsets of resources, it has been primarily associated with quality controls required as a condition of participation for providers. While regulations promulgating the standards for participating providers have been issued, enforcement has been a different story. Enforcement of the physical structure has received more vigorous application than enforcement of norms of care. While there are isolated examples of consumer participation, especially in non-profit homes, existing policy does not appear to have stretched that far. In fact, a recent report of the Oversight Subcommittee of the full committee indicates that the attempts to promote consumer knowledge through the public disclosure of survey reports on institutions participating in the Medicare program concludes that thus far the program has been a failure.

Restrictive reimbursement policies have skewed Medicare payment towards an institutional bias thus limiting the full use of all available health services. This policy has been particularly pronounced in the utilization of home health services under Medicare. Likewise, Medicare has approached health manpower with a limited prospective steeped in the established professions rather than encouraging the development of para-health professionals.

LINKAGE INCENTIVES

Present Medicare policies provide little incentive for linkage within any of our subsets. Accessibility is limited in the benefit package, containment policies and covered transportation services. Administrative complexity has marred even the most redeeming aspects of the program. There is no reference to other service needs. Medicare stands as a social program divorced from related government efforts.

MEDICAID

The federal-state Medicaid program finances the principal health care needs of 24 million poor people. The program will cost an estimated $14.2 billion in fiscal 1976, of which $7.8 billion is federal and $6.4 billion is state and local expenditures.

Under the law, states must extend Medicaid benefits to individuals eligible for aid to families with dependent children and, with certain exceptions, beneficiaries of Supplementary Security Income. States may, at their option, extend Medicaid coverage to the medically-needy—individuals who make too much money to make them eligible for cash assistance but still are unable to pay their medical bills.

Most of the criticism listed above concerning Medicare are applicable to its sister program, Medicaid. While the Medicaid benefit package is broader than that of Medicare, and while the program meets to a limited degree the long-term intermediate nursing and home health needs of eligibles, the restrictive eligibility criteria negates the progressive nature of the benefit package. Unlike Medicare, the tradition of Medicaid is that of a social welfare program cast in the stigma of demeaning tests for entitlement. The tandem effect of the 1972 utilization review and skilled nursing amendments have threatened the placement of many Medicaid beneficiaries with relocation to Intermediate Care facilities. The effect is to negate the Medicaid reimbursement benefit for skilled nursing care and to force the transfer of sizeable patient populations into institutions which are less able to meet their medical needs. Similar to Medicare, this program has had limited impact in containing the spiralling cost of health care services.

Medicaid's impact on the resource incentives have been equally questionable. With regards to the quality of care issue, the responsibility for surveillance, detection, investigation, and the prosecution of fraud and abuse has been placed primarily with the states. For the past ten years, there has been virtually no federal staff to investigate such violations, and it appears as if 38 percent of the state fraud investigators are concentrated in just two states. While Medicaid programs vary greatly from state to state, generally speaking the program has had the same conservative approach toward resource development and manpower practices as Medicare.

With respect to incentives for linkage, Medicaid contains many of the pitfalls of Medicare. Assessibility is not encouraged. This is particularly true during these periods of economic uncertainly where many state and local governments along with the federal government are finding it difficult to remain solvent. The program is administratively cumbersome encompassing lengthy determination and redetermination procedures. Finally, while interfacing more directly with other means tested programs within a state, there are serious gaps between the Medicaid program and its related human resource programs.

Mr. Rostenkowski [presiding]. Thank you, Mr. Brickfield.

In your statement you suggest that the cost sharing under medicare be adjusted to the income level. How do you propose that this part of the program interface with the medicaid program which presently pays the cost sharing for the categorically and medically needy?

Mr. Brickfield. First of all, we start out with a study by the Brookings Institution which says there should be some cost sharing.

Second, and I read the quote from my statement on page 7 from the Brookings' publication. It says that ". . . experience with Medicare emphatically suggests that uniform cost-sharing provisions will lead to wide disparities in utilization among income classes but that reduced cost-sharing for lower-income people can allow them to adopt patterns of medical care utilization similar to those of middle- and upper-income persons with similar health problems."

Therefore, we urge that the committee, if it must accept some form of cost sharing, the most equitable feature would be based on an individual's income and tied to the user's services.

Mr. Lane. Mr. Chairman, if I may, within the Comprehensive Medicare Reform Act the income categories are set in such a way that those individuals who are in the lower income classes would be covered without copayment. They would have automatically met the threshold cost.

It is only after one goes above the income categories that the copayment comes into play. So we have adjusted the copayment feature with the threshold catastrophic level. While our bill would retain a residual medicaid program, all services currently covered for the elderly under medicaid would be superseded by this bill, and there would be no need for the cost-sharing approach that is curently in the bill where the States pay the part B premium and deductible for medicare indingents.

Mr. Rostenkowski. Thank you, Mr. Brickfield.

Mr. Brickfield. Thank you, Mr. Chairman.

Mr. Rostenkowski. Mr. Jarman.

Welcome to the committee, Mr. Jarmin. Will you please identify yourself and your organization and proceed with your testimony.

STATEMENT OF M. STANTON EVANS, CHAIRMAN, AMERICAN CONSERVATIVE UNION, AS PRESENTED BY GARY JARMIN, LEGISLATIVE DIRECTOR

Mr. Jarmin. I am Gary Jarmin, and I am the legislative director for the American Conservative Union.

Mr. Evans could not be here today due to last minute change in his schedule, so I am just going to read his prepared remarks, If I may, for the committee.

I submit this testimony not as an authority on medical questions or as one who has a personal interest in the practice of medicine, but as a taxpayer and patient. It is my belief that passage of a national health insurance bill of almost any type, but particularly of the scope and character of various programs being considered by the Congress, would be injurious to me and many others like me in both of these capacities.

On most of the indices available to us, the practice of medicine in the United States, under an essentially private system of delivery, has been highly successful. Major diseases have been conquered, new technologies have been perfected, life expectancies have risen, and infant mortality rates have fallen. Yet despite these achievements, we hear a steady stream of complaints about the medical profession, fixing now on one and now on another aspect of medical practice as a supposed source of "crisis" requiring governmental action.

The nature of the crisis varies from case to case, but the principal allegations at present appear to be the shortage or maldistribution of physicians and other medical personnel, the ruinous effects of catastrophic illness, and the rising cost of physician care and hospital services. If we examine each of these in turn, I think the lesson to be derived is rather different from the conventional presentation.

In the matter of physicians and other medical personnel, it is apparent that we have the opposite of shortage. As noted by the National Planning Association, the United States has the highest ratio of physicians to population of any country in the world—174 per 100,000 in 1972 compared to 135 per 100,000 in Sweden. The number of new physicians entering the economy on an annual basis rose to 16,000 a year in 1972—9,200 from American medical schools, 7,143 from immigration. The number of auxiliary personnel has risen even more rapidly, increasing at roughly four times the rate of population growth.

Concerning "maldistribution" the figures are equally impressive. Of some 3,082 counties in the United States only 132 as of 1970 were without a practicing physician, and 125 of these had less than 8,000 population, while 50 had less than 2,000. Moreover, some 36 of these counties are adjacent to large standard metropolitan statistical areas that have numerous hospitals, clinics, and physicians. As noted by the Commission on Health Manpower in a 1967 report, "Even in rural areas, hospital facilities of 25 beds or more are within a 25-mile distance of all but 2 percent of the population."

In general, the deployment of American physicians matches the distribution of services and of our population generally. It would be irrational to isolate physicians from the bulk of the population, where their services are obviously most needed. As for physicians moving out of urban areas marked by rising crime rates, the analogy to other resources and services is again apparent. This is not specifically a medical problem, but rather one that requires a general restoration of public order.

In the matter of catastrophic illness, there is little evidence that Federal intervention is required, or even desirable. As noted by Michael Meyer, a specialist in medical insurance plans, the need for catastrophic coverage is extremely limited, and the data suggest that this need is being met by existing private health insurance plans.

Meyer observes that on an annual basis only eight-tenths of 1 percent of all Americans incur catastrophic illnesses for which expenses exceed $5,000. Of these individuals, almost 80 percent are either psychiatric patients or patients qualifying for medicare. The result is that less than two-tenths of 1 percent of all Americans, in any given year, incur catastrophic illnesses outside these special categories.

This is an exceedingly low risk level, and as we might expect, private insurance companies are more than willing to write policies against risks of this magnitude. The result is that, as concern about this issue has risen, and demand for catastrophic coverage has grown, increasing numbers of Americans have appropriate protection. At present, about 135 million people, or 3 of 4 Americans under age 65, have major medical coverage for catastrophic illnesses through existing insurance plans.

If these factors do not account for a medical crisis in America, what does? The usual answer is that there has been a precipitate hike in medical prices generally, and there is considerable validity to this complaint. Medical prices have been rising at a rapid pace, particularly in the hospital sector. This general increase in prices is a major irritant to medical consumers, and forms the major pretext for further intrusions by the Federal Government.

Yet if the testimony of our public officials and competent medical economists can be credited, the lesson to be drawn from this experience is exactly the opposite of what we are being led to suppose. For the analysis of these authorities is that the hike in medical prices experienced in recent years results from the existing level of Government intervention—most notably the Government subsidy programs of medicare and medicaid.

Among the people making this point have been former HEW Secretary Caspar Weinberger, economists within the Social Security Administration, and medical economists Herbert Klarman of New York University and Paul Ginsburg of Michigan State, among others. The essence of their testimony is that the steady growth of third-party payment, especially by Government, the present system of cost reimbursement, and the release of an enormous surge of monetary demand upon a relatively fixed supply have served to increase resort to medical services and bid up the prices of all the relevant factors.

The logic of the situation seems sufficiently obvious. To the extent that the price of a commodity or service is reduced at the point of consumption, demand will be increased. The price of such a good or service is a regulator of its use, and the pricing mechanism is a sensitive method for sorting out demand intensities. If that mechanism is eliminated, as has largely occurred in the field of medicine, some other regulator must take its place.

The point is made in the recently released report by the Social Security Administration entitled "Health Insurance Administrative Costs" authored by Ronald J. Vogel of SSA and Roger Blair of the University of Florida. These authors observe that "the inevitability of inflation results from the lack of a nexus between the payment for a medical service and the consumption of it. Because there is no direct link between what providers charge and what consumers are really willing to pay, there are no competitive pressures on providers to hold down costs. Consequently, prices in the medical care sector have risen at much more rapid rates than in other sectors of the economy. This has been particularly true as insurance coverage has broadened and deepened through the advent of Medicare and Medicaid."

So deposing, the social security study affirms the conclusion reached by almost every other authority on the question. At a recent seminar staged by the American Enterprise Institute, for example, medical economist Ginsburg observed that the rise of medicare, medicaid and third-party payments had removed the normal price restraints on utilization, thus creating present problems.

"In the United States," Ginsburg said:

> The system of hospital financing is approaching one where patients will have no incentive to consider price. Already, 90 percent of hospital expenditures are covered by third-party payments. * * * If third-party coverage is approaching 100 percent, it appears that neither charge nor cost reimbursement is consonant with a "quality" level less than the limit of technology. * * * With patients insensitive to price, and with costs or charges reimbursed, there is no restriction on increasing levels of quality * * * and quantity to the patients' saturation point.

The point has been confirmed as well by former Secretary Weinberger. "I have said many times, and firmly believe," Weinberger said:

> That the faulty design of medicare and medicaid is the principal culprit responsible for the superinflation of health care costs. The guaranteed government payment of health costs in virtually any amount submitted by the provider in the past, and with normal market factors absent in the health care area, inflation was bound to happen, and it certainly did.

The truth of these assertions is readily apparent from the medical spending—and pricing—record of the past 10 years. It is estimated that national outlays on health, public and private, grew to $118.4 billion in fiscal 1975, up from $25.9 billion in 1960. Federal spending grew even more abruptly, jumping from $5.9 billion in 1966 to $35 billion in 1975. Most of this increase, as the dates suggest, has been for medicare and medicaid. Medicare alone has quadrupled since 1967, jumping from $3.4 billion to $13.9 billion. Medicaid, meanwhile, has grown from $1.4 billion to $6.15 billion.

The medical price index has reacted to this influx of demand in predictable fashion. As more and more dollars have bid for a relatively stable supply of physician and hospital services, prices have pushed up at a vertiginous rate. In the latter part of the 1960's, both components of the medical price index expanded at double the rate which had prevailed before the arrival of medicare and medicaid. In short, existing intrusions have caused the problem that supposedly requires a new intrusion.

From this standpoint, two major observations immediately suggest themselves.

First, the so-called crisis in medical pricing is in considerable measure the result of the existing level of Federal intervention in the medical economy.

Second, given these economic factors, we can readily imagine the impact on medical prices if the present system of partial subsidy is broadened or converted into a system of total subsidy, as suggested in certain proposals before this body. In this event, the crush of demand and consequent upward push on prices would be unmanageable.

To the extent that the pricing mechanism is weakened or eliminated, some other mechanism must take its place. This means, in essence, rationing—a distribution of resources according to political and bureaucratic decisionmaking rather than the imperatives of the marketplace. This unhappy process has already manifested itself in such governmental efforts as PSRO and utilization review.

The ultimate results of this approach may be readily observed in Great Britain, where there are enormous waiting lists for surgery and patients are handled on an assembly line basis.

Unless we want the same kind of situation in America, there should be a rapid reversal of our medical priorities. Rather than studying methods of intruding government further and further into health care and weakening the pricing mechanism to the point of unmanageability, thereby intensifying our existing problems, we should be seeking ways of extracting government wherever possible from the practice of medicine.

I realize the many difficulties enfolded in this approach and have no magical suggestion for achieving the desired result. But I would respectfully suggest that this committee, with its resources and marshaled expertise, could usefully devote itself to this endeavor, rather than pursuing legislative proposals that would almost certainly make the problem worse.

Thank you.

Mr. ROSTENKOWSKI. Thank you, Mr. Jarmin.

Are there any questions of the witness?

Mr. Corman?

Mr. CORMAN. No questions, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Martin?

Mr. MARTIN. No questions.

Mr. ROSTENKOWSKI. That will conclude today's testimony.

The committee will stand in recess until 9 o'clock tomorrow morning.

[Whereupon, at 1:03 p.m., the subcommittee adjourned, to reconvene at 9 a.m., Tuesday, November 11, 1975.]

NATIONAL HEALTH INSURANCE

TUESDAY, NOVEMBER 11, 1975

House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The committee met at 9:04 a.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. The committee will be in order.

Mr. Sonnemann, if you will identify yourself, Ms. Wooden, and the organization you represent, you may proceed with your testimony.

STATEMENT OF ROGER C. SONNEMANN, VICE PRESIDENT, ADMINISTRATION AND EMPLOYEE RELATIONS, AMAX, INC., AND CHAIRMAN OF THE NATIONAL CHAMBER'S SPECIAL COMMITTEE ON THE NATION'S HEALTH CARE NEEDS, MEMBER OF THE BOARD OF DIRECTORS, U.S. CHAMBER OF COMMERCE, ACCOMPANIED BY ROSE P. WOODEN, ASSOCIATE DIRECTOR, ECONOMIC SECURITY, EDUCATION AND MANPOWER SECTION, U.S. CHAMBER OF COMMERCE

Mr. Sonnemann. Thank you. I am Roger C. Sonnemann, vice president for administration and employee relations of AMAX, Inc. I also serve as chairman of the national chamber's special committee on the Nation's health care needs and am a member of its board of directors. Accompanying me today is Rose P. Wooden, the committee executive of the chamber's special committee on the Nation's health care needs.

The chamber welcomes this opportunity to update its views on national health insurance. This statement supplements the testimony on national health insurance proposals given to the Committee on Ways and Means on May 31, 1974, the testimony on health insurance for the unemployed submitted to the subcommittee on March 7, 1975, and the statement submitted on national health insurance on April 15, 1975.

These issues, we think, are of vital concern to our membership which embraces more than 48,000 business enterprises, 36,000 trade and professional societies and associations and local and State chambers of commerce. The underlying membership is more than 5 million individuals and firms.

Our special committee on the Nation's health care needs, composed of business and industrial leaders and members of health professions, developed the national health care standards bill. The terms "reasonable" and "realistic" most accurately describe this bill. We urge caution in implementing any national health insurance proposals until solutions are found for the causes of health care inflation and until improvements are made in our planning of health care delivery systems, and until effective incentives are found to offset rapidly rising health care costs. The chamber supports the goal of a national health insurance system that would assure access to quality care for all Americans at reasonable total costs for services provided. Such a system should maximize the advantages of individual freedom of choice and of flexibility.

Any national health insurance program should recognize certain basis principles. It should, for example:

Provide for universal financial access to health care through both private and public means;

It should provide public financial assistance for the poor, near poor, and the unemployed;

It should build on our existing hospital and medical care delivery systems with underwriting and administration supplied by private enterprises;

It should protect individuals and families against the devastating impact of very costly and prolonged illness;

It should provide a benefit package which is comprehensive in scope;

It should provide for cost sharing on the part of beneficiaries; and

It should provide for effective measures to help contain spiraling costs.

When such a program is adopted, working Americans and the unemployed will have health coverage, as will those who are on welfare or who have low incomes.

We refer you to our exhibit A for elaboration, Mr. Chairman.

[The exhibit follows:]

Exhibit A

Recommendations on National Health Insurance Legislation

(Chamber of Commerce of the United States, Nov. 22, 1974)

The design and implementation of any National Health Insurance legislation enacted by Congress should be based upon the following principles:

1. There should be universal financial access to the coverage for essentially the entire population, through both private and public means. Where the employer-employee relationship exists coverage should be mandated. Employees should be required to accept coverage if employers are obligated to offer it. For small employers, or self-employed persons, coverage should be available from a special insurance pool. Where the poor and near poor are involved, coverage from a separate, government-assisted pool should be available.

2. The plan should build on our existing hospital and medical care delivery systems with underwriting and administration supplied by private enterprise, including commercial insurance and Blue Cross/Blue Shield plans.

3. The benefit "package" should be comprehensive in scope providing protection against a wide range of hospital and medical care expenses, i.e., hospital, surgical, diagnostic, lab and x-ray, radiation therapy and in-hospital medical expenses

plus out patient surgery, maternity, psychiatric, ambulance, post hospital extended care and physiotherapy, etc.

As part of the overall benefit "package", every covered individual should be protected against the devastating impact of very costly and prolonged illness—the medical catastrophy. Such protection should be through a major medical provision with no lifetime limit.

4. Benefits should be phased-in over a 5 year period to ease inflationary pressures and to ensure availability of services.

5. The plan should provide for a benefit equivalence test to recognize the varying needs and differences, including geographical, of individuals and groups thus allowing flexibility in the makeup of hospital and medical care plans. Also, current highly sophisticated and generous benefit plans should not be forced to add additional benefits and additional costs where the benefit equivalence test is met or exceeded.

6. The plan should provide for cost sharing on the part of beneficiaries by appropriate deductibles and co-insurance provisions.

7. Employers should be encouraged to make the mandated plan available through the process of administrative and judicial review with civil penalties assessed in instances of non-compliance.

8. Any NHI legislation should attempt to curb spiraling health care costs through fair and effective means. *First*, all hospital and medical care services should be subject to peer and utilization review, claims review and audit. Peer and utilization review should be carried out by physicians to insure that only medically necessary services are provided to both in-patients and out-patients. Employers should be permitted to contract directly with physicians to establish peer review, certified hospital admission programs and systems of accountability to determine whether a company's health care dollar is being properly spent. *Second*, hospitals and other institutional providers should be reimbursed on the basis of prospective budgets, with payments based on agreed rates for a fixed period of time. *Third*, duplication of facilities and provision of unnecessary services should be avoided by prior approval by local health planning bodies and non-payment for disapproved capital expenditures.

9. Any NHI legislation should provide for the option of enrolling in an approved health maintenance organization, such as prepaid group practice or medical care foundations, in lieu of coverage under a mandated plan. This option should include adequate safeguards to ensure proper coverage, high quality care and a limit on the employer's financial obligation equal to the costs of his existing health insurance program.

10. Any National Health Insurance program should be financed from both public and private sources. Employers, employees and the self-employed should pay the entire cost of the mandated program through health insurance premiums. Where the employer-employee relationship exists, the plan should mandate no more than a 50–50 cost-sharing of premiums with provision that an employer may voluntarily assume the payment of part or all of the employee's share of premiums. A program for the poor and near poor and unemployed should be financed from the general funds of the Treasury. Eligibility and individual premium payments should be based on income level or other appropriate measures. *No part of the cost of NHI legislation should be secured by any payroll tax.* This will lead to government control of health care delivery and undermine the present effective private enterprise system with respect to furnishing and financing health care.

11. The Medicare program should remain intact and unchanged by any National Health Insurance legislation. Medicaid should be repealed since it would be supplanted by the health insurance program for the poor and near poor.

Mr. SONNEMANN. The question is not so much, Should we provide health insurance coverage for all Americans? But rather, How should we design a new national health insurance program that is affordable by the Federal Government, the individual consumer, and employers?

We have learned that the traditional market controls inherent in the price system do not operate in the present health care system. This can be directly attributed to the rise in health insurance, private and public. It is the third party effect of health insurance which causes market distortions.

The cost of health is directly related to the scope and level of health care protection desired. Once the insurance premium is paid to the third party insurer, the natural incentives are there to demand and provide the best care if there is the slightest possibility that it might be beneficial. The increase in private and public insurance has acted, in part, not to replace personal expenditures for health but to increase them by making physicians and consumers alike less sensitive to costs.

Current social attitudes that health care is a "right" expose the health care system to an infinitely great demand. The decision to seek certain types of medical care is frequently made for consumers by doctors and hospitals. Lack of coinsurance and deductibles encourage overutilization and overloading of the health care system, particularly by the so-called "worried well."

The present reimbursement mechanisms and uncoordinated health planning have led to hospital bed overcapacity and attendant heavy hospital overhead. To make matters worse, every community is encouraged to develop a sophisticated medical delivery system often with the spur of Government funds.

Our health care system, however, has been termed a "nonsystem" because it is not organized on a rational basis which would provide services in the most cost effective manner possible. Many experts have said that the costs will not be brought under control until a basic restructuring of the system takes place. Health maintenance organizations are only one type of restructuring that may prove beneficial.

As the demand for quality medical care expands, supply expands less rapidly, because of many factors. Money isn't the cure. It is one of the problems. Medical services are maldistributed rather than unavailable. For example, there is a geographic maldistribution of physicians and an imbalance in the mix of physician specialists. National health insurance will not solve these problems. In fact, it will tend to aggravate problems of health care delivery in rural and inner city areas where medical facilities and physician services do not exist. Pouring more money into a national health insurance system will not solve the problems of those most in need in such areas.

Americans already spend more on health care than any other people. We are spending $118 billion this year—8.3 percent of the GNP up 0.6 percent from 1974—a rate of growth in excess of the 0.5 percent growth over the previous 5-year period. Yet we are slipping behind other nations in many important measures of health. The sobering fact is that the health status of the American people has not substantially improved. Increased Government subsidy of health care expenses, without substantial improvement in the efficiency of the health care system, will only accelerate the alarming rise in medical costs. Conversely, if efficiency is improved, there may be less need for Government subsidies.

CATASTROPHIC HEALTH INSURANCE

The chamber supports the concept of catastrophic health insurance and believes that Americans should be protected from bankruptcy brought on by medical bills, and as you know, Mr. Chairman, we have testified to this at an earlier time.

But any program which provides only catastrophic protection is incomplete and does not represent an adequate response to people's needs which go beyond the statistical probability of medical catastrophe. For example, such insurance would not encourage more cost-effective preventive care. Nor would it help children and young women of childbearing age who need regular checkups. Making available additional health dollars to pay for medical catastrophe would encourage providers to use the most advanced technology available regardless of whether or not the benefits can be justified. Medical treatment will follow the health dollars as they have in the medicare and medicaid programs.

Private catastrophic health insurance is available today at reasonable rates. Based on a recent survey, the Health Insurance Institute estimated that 150 million persons under 65 now have private catastrophic health coverage for $10,000 or more. This includes coverage under major medical, Blue Cross, HMO, and other high basic coverage plans, such as that of the United Auto Workers.

On the other hand, at the end of 1974, over 165 million persons under 65 had private coverage through hospital expense plans. This illustrates that a larger majority of Americans under age 65 have chosen to purchase coverage for the more probable hospital episode as distinguished from the catastrophic episode. It also illustrates the existing breadth and depth of coverage in these two areas.

We recognize the appeal of the new catastrophic proposal that allows an employer to choose between a private plan and a public plan administered by the Social Security Administration. But there are no caps, ceilings, or incentives written into the proposal to contain costs or improve the delivery of care.

Acceptance of payroll tax financing of health care on a universal basis—meshed with a Government operated program of catastrophic benefits for part of the population—would border on a total Government health care program. Experts question whether or not the 1-percent proposed payroll tax will do the job, given the current rate of health insurance cost increases.

This proposal comes at a time of growing concern over future social security deficits. This year, we will pay out more in social security benefits than is collected in payroll taxes by employers, employees and the self-employed. The 1974 annual report of the trustees estimated a long term 3 percent taxable payroll deficit in social security. Experts reporting to the Senate Finance Committee have estimated the deficit at 6 percent of taxable payroll. The Ways and Means Committee has learned that the trust funds may be depleted by 1980. Yet, this committee has been considering proposals to increase unemployment compensation payroll taxes on employers by $6 billion or more a year.

TIMETABLE FOR NATIONAL HEALTH INSURANCE

The Nation faces three big problems that must be resolved in our judgment before enactment of national health insurance legislation. These problems are: The slow recovery from recession and high unemployment; the continuation of inflation; and the energy crisis.

These problems have delayed national health insurance. The delay is fortunate, giving Congress and all interested parties time to reassess the value of national health insurance, its costs, and the economic problems it will cause.

The Federal Government has already plunged deeply into health care and without satisfactory results. Medicare and medicaid expenditures are estimated by HEW to jump from $25 billion in fiscal year 1975 to $30.4 billion in fiscal year 1977, an increase of $5.4 billion. Medicare expenditures will rise to $21 billion in fiscal 1977 from $11.3 billion in fiscal 1974. The inflationary increase in medicare and medicaid expenditures will exceed the total health budget of all other HEW health programs amounting to some $4.5 billion in fiscal 1976.

The enactment of medicare and medicaid offers an example of how not to proceed, I repeat, of how not to proceed—with national health insurance. The social conscience and political pressure which prompted the Nation to adopt these measures were not accompanied by a comparable effort to encourage large scale introduction of more effective systems for providing medical services. As a result, in the past decade, close to half of the increase in spending has been for higher prices for medical care rather than for increased services.

The inexorable rise in the unit price of medical care has led some to believe that national health insurance is the only way to control these costs. But our experience under medicare and medicaid is not reassuring in this regard. The unit price during the period 1950–75, has, increased from 4.1 percent to more than 8 percent of disposable income,[1] and we have footnoted the source for those statistics.

On the whole, the health insurance and medical care industries are serving the American people quite well. The most recent Rand Corp. report on the subject estimates annual premiums for private health insurance are approximately $29 billion in the United States. About $4 billion of this represents administrative services and risk-bearing performed by the health insurance industry. Nearly 9 out of 10 persons today have some form of protection against medical costs.

I want to emphasize this point because I said at an earlier time, "We have fortunately some time to give to consideration of these aspects before plunging into national insurance itself." Nearly 9 out of 10 persons today have some form of protection against costs.

The problems we are facing today in health care can be solved short of sweeping nationalization of health insurance. Under the economic circumstances, it is prudent to put new expensive Federal health insurance plans in perspective while we are trying to restore a healthy national economy.

GOALS FOR BETTER HEALTH CARE

The chamber recognizes certain goals for an improved health care system. These goals are: (1) Improved health care manpower; (2) better health care planning; and (3) improved health care delivery. They are consistent with the American traditions of freedom of choice, self-reliance and efficiency. Corporate interest in cost-containment and improved health services is logical, for the business community is the largest consumer of health care because it pays heavily for health delivery inefficiences.

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[1] The Bureau of Labor Statistics (BLS) price index of medical care rose from 53.7 to 132.5 between 1950 and 1975 (1967=100), while the general Consumer Price Index rose from 72.1 to 125.3. Thus medical prices rose by nearly 150 percent, while general prices rose by 74 percent. By implication, the demand for medical care is considerably price-inelastic.

HEALTH CARE MANPOWER

The national chamber, in general, supported the House passed health manpower bill, recognizing that geographic maldistribution of physicians has denied access to care for many Americans. We know that the present mix of physician specialists and the overabundance of superspecialists in certain areas, has had an inflationary impact on health care costs. This inflationary impact reflects the fact that, within limits, doctors create their own demand. We believe the House of Representatives acted responsibly in passing the health manpower bill which was partially aimed at effectively delivering health care to the poor, either in urban or rural areas, and improving the specialty mix of physicians.

The urban poor need better access to health care facilities which are responsive to the problems in urban ghetto neighborhoods. And all rural citizens, not just the poor, deserve more imaginative methods for delivering health care. Mobile clinics, effective emergency service, and computer monitored arrangements are possibilities. The problems seem to be primarily in purpose, leadership and organization and only secondarily in technology.

HEALTH PLANNING

Better responsibility, accountability and coordination of health care are needed. Businessmen are actively involved in implementing the National Health Planning and Resources Development Act (Public Law 93–614). The national chamber staff and the Special Committee on the Nation's Health Care Needs are developing useful information to help guide businessmen in making the difficult decisions involving their community's health needs.

Regulations of the health industry should avoid the mistakes made in the regulation of railroads, airlines and other industries. Truly effective health planning would stimulate improved services and reward innovative ways to contain costs, and not lock in traditional methods that are not cost efficient.

Needless duplication of services and wasteful competition for "prestige" purposes must be avoided. Business has become acutely aware of the inflationary impact of expensive medical equipment such as cobalt therapy machines and cardiac surgical units. Expensive medical equipment which is described as that costing over $100,000, purchased by the hospitals are subject to control by area planning agencies, but purchase of such equipment by individual doctors is not controlled. This can lead to unnecessary costs.

More responsibility is needed on the part of community hospitals. They should publish detailed financial statements, including contractual terms of payment for the services of specialty groups. The reimbursement formulas for hospital-based physicians (that is, radiologists, pathologists, and so forth) should assure that such services are not overutilized and that unnecessary equipment is not purchased by hospitals.

Businessmen are cooperating with community hospitals, developing such innovations as prospective reimbursement systems, taking into account hardship relief for hospitals.

Training programs are needed for those who serve as trustees or who are on the governing boards of hospitals or similar institutions, to insure enlightened service. Businessmen can and are participating in decisions that affect the cost of hospital care. Application of sound business methods and management techniques often have a decided effect favorable on costs.

The national chamber has also recognized the serious consequences of medical malpractice suits, including rising insurance rates, the practice of defensive medicine, the increasing frequency of suits, the size of awards, and the adverse effects on already limited manpower. We are encouraging local and State chambers and the business community to work with the various interest groups involved to find statewide solutions to this problem at the State level.

Finally, individual company indemnity benefit plan design can have a substantial impact on the cost of health care. Private indemnity plans should be designed to deemphasize the most expensive forms of care, such as hospitalization and increase ambulatory and preventive care. Also, cost-containment incentives through deductibles and coinsurance will help sensitize both patient and health care providers to costs. This will encourage patient involvement in the decision as to the level of care provided, and believe me, there is no more covering up of these costs than is contained in the employer pay all, employer pay nothing, kind of plan where the service is provided, the cost is paid and the employee rarely if ever pays anything more than the cost of the TV in the room, perhaps.

This definitely hides from him the realization as to cost of the care that he has received.

HEALTH CARE DELIVERY SYSTEMS

Improvement is needed in the way we deliver health care. The present delivery system, aimed at treating the sick, puts the individual doctor at the point where the patient enters the system for care. The doctor who screens every patient has been described by the noted health economist, Victor Fuchs, as the "gatekeeper." Doctors are scarce, expensive and require a lengthy period of education, compared to other health care personnel. We should experiment widely but carefully to multiply the effectiveness of doctors without sacrificing quality of care.

We think Congress acted responsibly in passing the original Health Maintenance Organization Act (Public Law 93–222). The chamber supported this act and the recently offered amendments (H.R. 9019), recognizing the need to encourage experimentation with alternate delivery systems. The amendments were developed when it became clear that some of the requirements of the original act were excessively strict on employers and providers and had the effect of placing developing HMO's at the competitive disadvantage with other delivery systems.

Prepaid group practice gives doctors only one experimental model besides solo fee-for-service practice. The HMO approach stresses the idea that if the structure and incentives of the private medical care system can be properly set, the system will work itself out with the least intrusion by the Federal Government into the private practice of medicine.

HMO's differ from traditional health insurance programs through responsibility for providing medical care to their enrollees, while an insurance plan merely pays for specific covered purposes. The HMO must provide care to each enrollee, even if it operates at a loss, which gives the HMO every incentive to be cost conscious and cost effective.

Generally speaking, the business community has recognized the potential savings that can be achieved through efficient HMO's.

During the last 16 months, the medical care components of the Consumer Price Index have been rising at an annual rate of 13.1 percent with about 45 percent of personal health care expenditures going for hospital care. Recent studies show that on a nationwide basis, HMO's use only half as many beds per capita as the national average of Blue Cross-Blue Shield subscribers.

It is interesting, also, to note recent cost increases of Federal employee's health benefits plans. Blue Cross-Blue Shield subscribers and those covered by Aetna insurance will experience a 35-percent rate increase. Last year, the increase was 10 percent. The Blue Cross-Blue Shield increase could run as high as 48 percent if Congress fails to repeal or modify a change in the Social Security Act that on January 1 will transfer medicare responsibility for Federal retirees from the Social Security Administration to the Civil Service Commission.

In sharp contrast are the rate increases among the Nation's prepaid, HMO plans. Enrollees in Kaiser plans in California will pay only 10 to 20 percent more due to their avoidance of costly hospital care. The University Affiliated Health Plans in the Washington, D.C., area will increase employee contributions only 3 to 8 percent. However, the similar Group Health Association expects increases of between 24 and 38 percent.

Most Americans still appreciate the advantages of a plurality of choice of health care. Some may prefer group practice, fee-for-service, or some modified plan depending on their personal feelings, economic status, or geographic location. HMO's are not a panacea, or even suitable for everyone, but they need to be developed as one way of injecting more competition into the health industry.

SUMMARY

And finally, Mr. Chairman, we believe increased Federal subsidizing of health-care costs, without substantial improvement in the effectiveness of the health-care system, will only accelerate the current, alarming rise in medical costs. In other words, we believe without first investigating and solving the problems of inefficiencies in delivery of the present system is putting the cart before the horse.

There is little evidence that many people are being denied medical care because of their inability to pay.

In the meantime, as Congress addresses itself to the urgent problems facing the economy, we support this committee in its effort to reexamine all aspects of the national health insurance debate.

Because national health insurance is so potentially inflationary, and because insurance is not an acute problem for the great majority, a national health insurance plan should be modest or postponed until a really effective cost control strategy is agreed on.

Thank you, sir.

Mr. Rostenkowski. Thank you, Mr. Sonnemann.

In your testimony, you suggest that more responsibility is needed on the part of the community hospitals, and that they should be required to publish detailed financial statements including their reimbursement arrangements, for radiologists and pathologists. Would you recommend that we should require this under medicare as well?

Mr. Sonnemann. Yes, I would say so. I think that one of the greatest controls of abuse is the public view and I think that we need to have more and better information made public in respect of these hospital charges. Yes, sir.

Mr. Rostenkowski. Thank you.

Mr. Duncan?

Mr. Duncan. Thank you.

I would like to welcome both of you to the committee.

Mr. Sonnemann, do you think that the Federal Government should concern itself with the problem of malpractice insurance? You mentioned that as being one of the problems.

Mr. Sonnemann. We just finished a very extensive debate on all aspects of this within the chamber of commerce and our conclusion is that this is best handled at the State level, because of the varying tort laws in the various States and, therefore, we recommend that this be solved by the States and, I think, as of now, some 26 of the States have done so.

So, our recommendation is not a federally imposed blanket, but rather the encouragement that each State within its own framework of laws and problems should handle this problem.

Mr. Duncan. You also mentioned that HMO's are—well, we had testimony a few days ago that out of 173 HMO's that operate only about 30 are close to breaking even. Are you aware of that?

Mr. Sonnemann. Well, I was aware that there is a considerable problem in the HMO area, but I am also aware that in this concept of the total coverage including the annual checkups and the whole problem being handled by group medical practice, has within it the seeds of cost containment and competition which I think are healthy for the health industry in this country.

We, at the chamber, were delighted with the HMO bill that was passed. We support the concept. And we think that they should be given a chance to operate.

Now, undoubtedly, there are imperfections, undoubtedly changes will be required. But the concept has, I think, a great value to the country.

Mr. Duncan. How can we improve it, if they are not breaking even, what would you suggest?

Mr. Sonnemann. I think the cost increases are—there are going to be some cost increases, undoubtedly, required in terms of the group involved.

I think that it is too early to say exactly what we can do, but we should pick the most successful ones, particularly the Kaiser plan and others, that have had a fine record of cost containment and service provided and seek to emulate those strong points which they have.

Mr. Duncan. I understand Kaiser is having some difficulty now.

Mr. Sonnemann. Yes, they are, of recent times, having some difficulty.

Mr. Duncan. I understand Kaiser is having some difficulty now.

Mr. Sonnemann. Yes; they are, of recent times, having some years, of successful operation and I think that they will again be able to handle their problems.

One thing that I think is for sure, the recent cost increases in insurance rates in Blue Cross-Blue Shield and so forth which reflect the soaring 16 percent per year compounding cost rise in the total health care of this country, are finding some expression in the group practice and, I think, this cost increase has to be recognized, but it will be in my judgment a great deal more modest than is the case elsewhere.

Mr. Duncan. What suggestions or plan would you recommend that we might have better distribution of health care personnel? You mentioned the urban poor in your statement, page 7. What would you suggest?

Mr. Sonnemann. This is a very difficult problem because people—and I know from personal experience in my hometown in Illinois—the difficulty we had in getting a doctor to come in even after a clinic was built by publicly subsidized funds, and the thing was set up next to the local hospital.

I think that incentives of the kind I have described by smaller communities in rural areas and by the ghetto—facilities in the ghetto area can and will attract doctors. I think that the problem has been that they do not want to spend money to set up their own clinics in these smaller areas, and as a consequence there has been less than satisfactory distribution of doctors. It is easier to set up on Park Avenue than it is to set up in some rural county where maybe there is only one doctor for, perhaps, 100,000 square miles.

Mr. Duncan. One other question, and then my time is up. What are your thoughts on rural areas, what are your thoughts on nurse practitioners for the rural areas and paramedical help in general?

Mr. Sonnemann. I think that because of the problems of educating a doctor and the long time required, first of all, to get your M.D. and your internship in, I think that the use of paramedical services has to be expanded in this country. I think there have to be some imaginative means of transportation, perhaps, more frequent use of helicopters in order to get the patient requiring the service into a hospital area.

I think that there are many things that can be done, the use of paramedics, the use of improved transportation, perhaps a mobile clinical unit that goes around giving chest X-rays and this sort of thing, all of these have to be tried in order to provide a better level of care in the rural areas where doctors and hospitals are few and far between.

Mr. Duncan. Thank you very much. Thank you both.

Mr. Rostenkowski. Mr. Corman will inquire.

Mr. Corman. Thank you, Mr. Chairman, I have no questions.

Mr. Burleson. No questions, Mr. Chairman.

Mr. Martin. No questions.

Mr. Rostenkowski. Mr. Cotter?

Mr. Cotter. Thank you very much, Mr. Chairman.

Mr. Sonnemann, on page 6 of your testimony you state that nearly 9 out of 10 persons today have some form of protection against medical loss.

Mr. Sonnemann. I am sorry, sir, I didn't hear you.

Mr. Cotter. On page 6, you say nearly 9 out of 10 persons have some sort of protection against medical loss.

Mr. Sonnemann. Yes.

Mr. Cotter. We have estimates that it varies from 75 percent for those under 65 have some type of coverage up to the figure which you have submitted, so there is disagreement in this area.

Now, my question is this: You recommend a catastrophic type of program; am I correct?

Mr. Sonnemann. Inclusion of a catastrophic provision in the structure of national health insurance, yes.

Mr. Cotter. How would you provide for these estimated 10 to 25 percent of the people under 65 who are not covered by any insurance?

Mr. Sonnemann. Our view is expressed in the national health care standards bill, the Fannin bill. First of all, you build the basic structure whereby a specified benefit structure would be provided. This would include all of those who have the employer-employee relationship. There would be pools available for the self-employed under which they could subscribe. Those who are excluded, the unemployed, poor and near poor, working poor would be provided out of a Government, a Federal fund. This would provide a basic benefit structure for everyone.

Mr. Cotter. Supported by tax dollars?

Mr. Sonnemann. Yes.

Now, as regards the insurance for which no provision can be made by employer-employee relationships, yes, sir, that is correct.

But you build on top of that a catastrophic provision which the Fannin bill does provide that at a certain point the catastrophic provision kicks in and it prevents the bankrupting of families.

The opposition that we have publicly stated to a catastrophic bill standing by itself is that it doesn't take into account the approximately 15 to 20 percent who currently have no basic coverage and it is like trying to build a house by starting at the second story.

Mr. Cotter. Do you have any estimates of what the cost would be to provide this primary care for this 10 to 15 to 25 percent?

Mr. Sonnemann. I think I would like to verify this and submit the evidence at a later time. My recollection is that the last time that we had it costed out and we did have our bill costed out, it was something on the order of incremental $4 billion. But I would like to——

Mr. Cotter. This is for the primary coverage?

Mr. Sonnemann. Yes.

Mr. Cotter. How about the catastrophic?

Mr. Sonnemann. This is the total.

Mr. Cotter. The total to provide the primary coverage for 10 to 25 percent who have no basic coverage and this is all estimated at $4 billion?

Mr. Sonnemann. This is my recollection subject to confirmation. I have to go back and look at a book.

Mr. COTTER. Thank you.

You make a strong point for the case that improvements are needed for the way in which we deliver health care. Yet you still recommend that we build a national health insurance program on existing hospital and medical care delivery systems which are in existence now. How do you reconcile that?

Mr. SONNEMANN. Well, if you will remember the thrust of what I have said this morning, sir, it is that before we proceed on that national health insurance, and passing a bill on it, we need to readdress ourselves to the problems of improvement in delivery and cost efficiency of the present system however imperfect it might be.

If we go to a national bill and do it quickly without first getting at these inefficiencies, we may very well lock in a number of these inefficiencies in the national bill and this would be to the detriment of the country. So, I think that the risk—at the risk of incurring the wrath of some people, that we have studied this to death and we don't need to study any further.

I urge that we do study the inefficiencies and the problems further before proceeding to legislation.

Mr. COTTER. I see. Thank you very much. My time is expired.

Mr. ROSTENKOWSKI. Mrs. Keys?

Mrs. KEYS. No questions.

Mr. ROSTENKOWSKI. Thank you, Mr. Sonnemann.

Mr. SONNEMANN. Thank you, sir.

Mr. ROSTENKOWSKI. Dr. Parrott, Dr. Palmer, and Mr. Peterson?

Welcome to the committee, gentlemen. If you would identify yourself and proceed with your testiminy the committee is ready to receive it.

STATEMENT OF MAX H. PARROTT, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY RICHARD E. PALMER, M.D., PRESIDENT-ELECT; AND HARRY N. PETERSON, DIRECTOR, DEPARTMENT OF LEGISLATION

Dr. PARROTT. Thank you, Mr. Chairman. I am Max H. Parrott, president of the American Medical Association. I am a practicing physician from Portland, Oreg., and with me today in presenting association testimony on this important subject of national health insurance is Richard E. Palmer, M.D., president-elect of the American Medical Association from Alexandria, Va.

Incidentally, we are both practicing physicians, I in the field of obstetrics and gynecology, Dr. Palmer in pathology. Also with us is Harry N. Peterson, director of our department of legislation at the American Medical Association.

Mr. Chairman, we are pleased to have this opportunity to appear again before you to express our views on national health insurance. The subject of this legislation has been raised many times during the past three Congresses. Once again national health insurance is under close scrutiny by interested Congressmen, committees, administration officials, and the public. I will take the liberty of not reading the whole text which is before you because of time constraints.

Mr. Rostenkowski. Without objection, we will place your entire text in the record.

Dr. Parrott. The extended discussion on national health insurance which has taken place during the past years has been beneficial in many respects in analyzing the issues and in evaluating the impact upon society.

We have observed a shift in attitude toward such a national program with an increased awareness and concern on the part of most interested parties as to the magnitude of the problems involved. These problems have been brought into better focus as a result of evidence of the effects of governmentally administered and controlled programs both here and abroad.

Our national priorities have also shifted because of the effects of the changing economy, and the devastating effects of inflation on all segments of our society.

The public has expressed among its major priorities a concern with inflation, with the state of the economy, and with crime. National polls have indicated that national health insurance is of low concern.

During this same period of time significant changes have taken place in our health system through increased manpower programs, increased facilities construction, increased levels of private health insurance coverage, and a variety of other programs. There is fuller realization and acknowledgment that this country's health system—under attack by many in the course of the national health insurance debate—is indeed superior to any other in the world.

Mr. Chairman, we will amplify on these points as we proceed in our testimony.

Improvements in our health system are continually occurirng, and the system is increasingly effective in responding to the needs of our society. Individuals who have recently testified before you have urged deliberation and caution in considering any national health plan. This will assure that our excellent system will continue to improve and will not suffer the stifling effects experienced in other countries.

When considering a national plan for this country it is necessary to take cognizance of the strengths of our method of health care delivery. I would like to review briefly some of those strengths with you at this time.

First: American medical service and medical technology have developed at an unparalleled rate, along with American scientific achievement in general. This has all happened since World War II. Presently in this country there is more and better medical technology than anywhere else in the world. And that technology has been fostered and achieved in the absence of a national health insurance program.

Second: There are more physicians being graduated from medical schools at this time than at any other time in our history. The estimated number of graduates for this year is nearly 13,000, a 72-percent increase in 10 years. In addition, approximately 50 percent of those entering graduate medical education, that is, specialty training; are now in medical specialties considered as primary care—a goal which was not expected to be achieved for several years [see attachment 1].

[Attachment No. 1 follows:]

CHANGES IN "PRIMARY CARE" RESIDENCY PROGRAMS AND 1ST-YEAR POSITIONS 1968–73

Specialty	Number of approved programs		Percent change 1968–73	Number of 1st year positions filled		Percent change 1968–73	1st year positions filled, number of United States and Canadian graduates		Positions filled, number of FMG's		Percent FMG's	
	1968	1973		1968	1973		1968	1973	1968	1973	1968	1973
Family practice	0	206	----------	----------	766	----------	----------	720	----------	46	----------	6
General practice	154	51	−200	254	176	−98	116	33	143	143	56	81
Internal medicine	419	433	+6	2, 589	4, 139	+60	1, 801	3, 154	788	985	30	23
Obstetrics/gynecology	358	347	−3	759	1, 003	+33	433	675	326	328	43	32
Pediatrics	260	274	+5	1, 002	1, 699	+69	651	1, 141	406	588	41	33
Total	1, 191	1, 311	+9	4, 604	7, 783	+69	3, 001	5, 723	1, 663	2, 090	36	27

Note: U.S. graduates: 1968, 7,973; 1973, 11,613.

Dr. Parrott. This is being accomplished in the absence of national health insurance or Federal controls.

Third: More medical schools have opened in the past 10 years than were opened in the previous 20 years. We now have 114 medical schools as compared with only 88 in 1965 and this is illustrated in attachment No. 2 attached to our testimony.

[Attachment No. 2 follows:]

STUDENTS AND GRADUATES IN MEDICAL AND BASIC SCIENCE SCHOOLS, 1930–75 [1]

Year	Number schools [2]	Total enrollment	1st year	Intermediate years	Graduates
1930–31	76	21,982	6,456	10,791	4,735
1935–36 [3]	77	22,564	6,605	10,776	5,183
1940–41 [3]	77	21,379	5,837	10,267	5,275
1945–46	77	23,216	6,060	11,330	5,826
1950–51	79	26,186	7,177	12,874	6,135
1955–56	82	28,639	7,686	14,108	6,845
1956–57	85	29,130	8,014	14,320	6,796
1957–58	85	29,473	8,030	14,582	6,861
1958–59	85	29,614	8,128	14,626	6,860
1959–60	85	30,084	8,173	14,830	7,081
1960–61	86	30,288	8,298	14,996	6,994
1961–62	87	31,078	8,483	15,427	7,168
1962–63	87	31,491	8,642	15,585	7,264
1963–64	87	32,001	8,772	15,893	7,336
1964–65	88	32,428	8,856	16,163	7,409
1965–66	88	32,835	8,759	16,502	7,574
1966–67	89	33,423	8,964	16,716	7,743
1967–68	94	34,538	9,479	17,086	7,973
1968–69	99	35,833	9,863	17,911	8,059
1969–70	101	37,669	10,401	18,901	8,367
1970–71	103	40,487	11,348	20,165	8,974
1971–72	108	43,650	12,361	21,738	9,551
1972–73	112	47,546	13,726	23,429	10,391
1973–74	114	50,886	14,185	25,088	11,613
1974–75	114	54,074	14,963	26,397	12,714

[1] To appear in "JAMA" in final issue of 1975.

[2] Prior to 1956–57, schools in development were not included.

[3] For the years 1931–32 through 1941–42, 2 schools reported total enrollment and graduates only.

Dr. Parrott. Many of these schools are emphasizing primary care and are located in nonmetropolitan or physician shortage areas. This, too, has been done in the absence of a national health insurance program.

Fourth: Statistics show that presently the private sector has made available to the population basic health insurance benefit policies covering 80 percent of the total population. In addition that same private sector provides catastrophic benefits for three out of every four persons in this country. The bulk of the remaining population has access to medicare/medicaid. A very small percentage represents people who, unfortunately, do not now have such insurance. Of significance, we note what while there is an increasing amount of private insurance, the total percentage of health care expenditures for private insurance benefits for the under-65 population has steadily increased from 1966, also, total out-of-pocket personal expenditures, which include premium payments, have decreased during that time. Moreover, this massive private health insurance coverage has occurred without stimulus of a national health insurance program.

It is also necessary to point out that if we had adopted programs similar to those of other countries our present strengths would have been compromised and jeopardized.

Mr. Chairman, these great strengths which we see in the health care system of this country are the ones upon which we believe it is most appropriate to build any program of national health insurance. It is both reasonable and obvious that these aspects must be accentuated rather than adopt a program suggested by some which not only would impose a system of Federal administration upon our health system but would also attempt, for some reason still unclear to us, to restructure the entire system.

We do, of course, recognize that there are some weaknesses within the present health care system. But we would hasten to point out that weaknesses are in the process of being rectified by our present responsive system without the need for a national health insurance program.

Manpower shortages are being overcome, alternative delivery systems are under experimentation, new types of providers are being utilized on an increasing scale, greater health education is being carried on by many groups, and new public awareness of the impact of total environment upon health is being aroused.

However, one significant problem which does remain, and which appears to us as a primary concern of the public, is the one of financial access to care, particularly in view of advanced medical technology and increasing health care costs, as well as the state of our economy.

As you hear testimony from advocates of those programs which would attempt to restructure the system as well as to provide financing mechanisms, I would urge you to keep in mind not only the foregoing essential consideration, but also the following basic thoughts concerning medical care in the United States today.

First: The need for catastrophic coverage is to assure that if such expenses do occur the individual will be able to pay from a source other than his own pocket. Nevertheless, this insurance for most people under 65 in reality is only an assurance for peace of mind since for most of them, the catastrophic occasion will never occur. The major need remains access to full care.

Second: Preventive health care, touted by many supporters of other bills as achieving a superior state of health if enacted, is limited in its effectiveness under any health insurance program. National health insurance cannot correct many conditions leading to serious illnesses and to suggest otherwise amounts to overpromise. For example, how would any physician stop his patient from smoking? What will convince anyone not to overeat or not to pursue an improper diet? Who can be forced to exercise? What will be done to assure adequate housing, clean air, proper working conditions, and a healthful environment? What about boredom, indifference, depression, lack of family attachments? Who will stop drug addiction and/or alcoholism? What about injuries and deaths caused by accidents? We could continue to enumerate many other issues which, whether generally recognized or not, are a part of preventive health care which have a definite, direct bearing upon life styles, quality of life and of health, but which cannot be ameliorated by any national health insurance program.

Third: It must be pointed out that one of the very basic reasons for present concern over the high cost of care can be directly traced to the success of medicine in recent years in the development of new technology. The elderly live longer today because of better medical technology. The seriously ill or injured are kept alive and eventually returned to normal life through the intervention of more highly skilled personnel and more complex equipment. Organs are transplanted, and people are able to carry on their lives. Today we treat and maintain the chronically ill and the seriously ill and the injured beyond what could even be imagined 20 or 30 years ago. In addition, health facilities are expensive because of the necessity to comply with present statutes and regulations intended to foster quality care. In addition, labor, equipment, and supply costs are higher. Although some costs might be reduced through a system of strict rationing, we must pose the question as to whether Congress would desire such a system at the expense of continued development and application of medical technology.

All of these points which I have reviewed with you strongly mitigate against a restructuring of our present system.

With these concepts in mind, I would urge you to look to the fundamental issues in the proposed national health insurance plans particularly in the methods of financing and administration.

In these two elements the plans vary considerably.

Some plans would tax payrolls through social security taxes to fund a program administered and controlled by social security. Others would more realistically rely upon the present strong points in our system by requiring employer coverage and insurance carrier administration in the private sector.

This latter type plan recognizes the important role of the private sector as well as the administrative limitations and shortcomings of the Federal bureaucracy. It also recognizes the fact that administration of a national health insurance program is better performed in the private sector. Administration in the private sector is more realistic when one considers the mounting evidence of problems arising in national programs which are prototypes for proposals now advanced involving government administration.

We need only call attention to European national health insurance programs as examples. When their central government took over the responsibilities for financing and administering programs, the growth and development of facilities, particularly and technology to a lesser extent were frozen at the level at which central government took control. Since that time the governments have been faced with increasingly antiquated facilities, with a growing dissatisfaction with the government system by both providers and patients, with an exodus of trained personnel to other countries, with increasing tax liability, with increase in costs, with waiting lists of 1 or more years, and which the inability of government to cope with rationing of health care. And it must be remembered that these problems have occurred in countries which are, as compared with the United States, small in area, compact, and homogeneous in population. Factors which should really help to assure success and where the population is inclined to look to the central government for assistance in many areas.

In our own country, the program which comes closest to an example of a national health insurance program for the public is medicare, a program which has benefited the elderly. However, this program has been characterized by overzealous bureaucratic control. In fact, its method of administration cautions against adopting any such similarly administered program for the general public.

As a final cautionary note, we would urge you to consider the inflationary impact upon the economy of a governmentally financed and administered program. We are all aware of the present difficulties through which our economy has been passing during the past 2 years. The Federal budget has been near the breaking point with a scope of deficit spending which is staggering in comprehension. Federal spending has arrived at the point at which the public is unable to withstand the two-pronged assault on it of inflation caused by deficit spending and of high taxes imposed in order to support Federal programs.

Mr. Chairman, in order to appraise the factors leading to rising costs in health care, this association is convening a national commission on the cost of medical care to be composed of individuals representing various sectors of the health care field and of the public.

In the meantime, however, Mr. Chairman, in order not to increase inflationary pressures and deficit spending, nor to hinder medical technology and the forward strides taking place in health care development, we must caution against any federally controlled and administered national health insurance program. Should we rush into such a system, the result will be a decrease in quality care and in availability.

We would also caution that no national health insurance system can achieve its goals without the support and commitment of providers of services. Artificial and unrealistic limitations on reimbursement or interferences with the practice of medicine will curtail availability of service and defeat the purpose of the program.

Mr. Chairman, this concludes my statement. At this time, I will call on Dr. Richard Palmer to continue with our testimony.

Dr. PALMER. Thank you.

Mr. Chairman, members of the subcommittee, the health care system of this country is a pluralistic one, a composite of various private initiatives and public programs. It is a system which encourages innovation and competition by providing incentives for organizational change and offers opportunity for improvement of quality care.

The public interest would be better served if we examine the goals of NHI within the context of the existing system and direct our energies toward perfection of this system in meeting the health care needs of this Nation.

Needed improvements can be brought about without gambling on a whole new medical health system whose effects and efficiencies, in the main, are unpredictable. We offer our plan for maximum health services for all persons through comprehensive insurance protection under a proven system which provides the finest health care in the world, and which can be financed in the private sector with a minimum of Federal support. This is the "Comprehensive Health Care Insurance Act of 1975" (H.R. 6222).

H.R. 6222 would establish a program to assure that every person has equal access to high quality medical and health care regardless of ability to pay. For the poor and for the affluent alike it provides identical coverage and includes protection against both the ordinary and catastrophic expenses of illness that an individual or family encounter.

Coverage would be provided for all inpatient and outpatient hospital care, 100 inpatient days a year in a skilled nursing facility, and all home health care services. It also provides: full physician services including all medical care provided under this direction; a full range of preventive services including physical examinations, immunizations and inoculations; well-balanced care; X-ray and laboratory services; ambulance services; and full psychiatric care. Children under age 7 will be fully covered for dental care, and this age limit will be raised each year until all persons under the age of 18 are covered; adults would be covered for emergency dental care.

Cost-sharing will apply as a safeguard against abuse, but will apply in moderation so as not to deny benefits to persons in need of care who cannot meet such costs. There is no deductible in our plan—no fixed amount is required to be paid before benefits begin. Benefits will begin immediately, with coinsurance set at 20 percent with the full amount of coinsurance being related to income. However, a fixed ceiling on the amount of coinsurance that any individual or any family will be required to pay in a year will apply to all persons. The poor, however, will not have to pay any coinsurance.

Most Americans are currently covered by employment-based insurance, and the premium is paid in full by the employer or shared between employer and employee; the total cost is thus paid in the private sector and without Government involvement. H.R. 6222 mandates the employer to offer coverage for employees and their families, thereby continuing a method of protection with which they all are familiar and which can be readily put into operation. The mandate gives legislative assurance that the full coverage will be provided, that the employer will pay at least 65 percent of the premium and, accordingly, that the employee will have only a limited participation in premium cost.

Those who are unemployed or poor will be entitled to Federal participation in the premium but they—like all others—will still have a choice of private coverage—an insurance policy, if you will, a Blue-Cross/Blue Shield plan, a group prepayment plan (including HMO), or any other plan meeting the program standards of adequate coverage. The amount of Federal contribution would be scaled according to income of the insured—and the Government would pay the full premium for the poor. On the same basis, Federal participation would assist medicare eligibles in obtaining supplemental coverage to bring their benefits up to the level contemplated by the new insurance program.

Simple mechanisms built into the program facilitate the Government's premium participation without resort to a cumbersome means test. A premium participation table enables the individual to assess readily the amount to which he is entitled. He may buy his insurance, pay the full premium and claim the Government share as a credit against tax on his income tax return. Or he may arrange to pay only his share of the premium, if any, prepare a claim form, and have the carrier bill the Government for the premium balance.

Most Americans believe that the role of Government financing in health insurance should be directed toward making quality care accessible to those who cannot afford to meet the expenses of such care. This is an underlying precept in our program of private insurance through employment—financed primarily in the private sector—and premium assistance by Government for the poor and the lederly. It is in sharp contrast to the financing in H.R. 21 that would impose on our tax system—already strained—the burden of some $50 billion in new social security taxes and the matching from general revenues of an additional $50 billion in order to support a federally controlled and administered health care system under which all services would be supplied by providers and professional practitioners under contract to the Government.

There is no basis for assuming that health care financing can be better or more economically adminstered in the governmental sector than in the private sector. On the contrary, Government administration has been shown to be more costly. We agree with a former Secretary of HEW that elimination of the profit factor, through the Social Security handling of health insurance finances, will not bring economies and efficiencies, the financing of health care is too important to the American people to turn over to a Federal bureaucracy.

If we allow Federal administration, we risk creating a national program which is unresponsive to particular needs and lacking in sufficient stability and innovation. We need a health care system that has room for and will reinforce the strengths of private initiative, not one that will stifle them under piles of paperwork and Federal regulation. It is our firm conviction, therefore, that any national health insurance program should be administered through the private sector.

If in the view of Congress an urgent need for national health legislation exists, we commend for your specific approval H.R. 6222, which would preserve the flexibility of our medical system, and build on the real accomplishments of American medicine. It stresses the major contribution made by the private sector of the economy and takes advantage of private institutions and industries. It attempts to hold to a minimum its demands upon Government, both for tax dollars and for the inevitable controls that go with them and does not thrust upon the Government a tremendous program of health spending to be financed primarily through new taxes.

We see, on the other hand, in some of the other proposals now before the Congress, elements which threaten the existing system of health care delivery and the high quality of care it affords. We shall touch on only a few of these.

We have already indicated our strong opposition to H.R. 21. We also strongly oppose a public utility approach to health care delivery as conceived in H.R. 1. Newly created entities—health care corporations (HCC's)—would be operating under franchise of the State Health Commission (SHC), in designated areas within a State, and would provide services directly or through affiliates within their franchised areas. Each State Health Commission would be under mandate to divide the State into health care corporation areas and blanket the State with health care corporations. The State Health Commission would also have ratemaking authority. In addition to the special Federal subsidies for the development and operation of health care corporations, provision is made for special premium subsidies for health care corporation enrollees. In the interest of good medical care, we have advocated a policy of pluralism which affords an individual or family a variety of health care delivery methods, and a choice of the kind of care they will receive. We must, therefore, reject the discriminatory Federal funding in support of a single method of health care delivery. We reject also, as undesirable and unnecessary, the State franchising of health care operations and public utility regulation.

H.R. 1 specifically requires that services of certain physicians (such as radiologists and pathologists) be paid as hospital services, thus making them subject to the institutional ratemaking provisions. This is highly objectionable. Any plan should properly recognize the physician's professional service as being distinct from hospital services, and any provisions for institutional reimbursement should not be interpreted to include the professional services irrespective of the setting in which the professional services are provided. This differentiation from hospital services should apply to physicians services under any bill, including H.R. 6222.

Another bill, H.R. 10028—identical with S. 2470, the Long-Ribicoff bill in the Senate—emphasizes catastrophic coverage. Revised from its form in the previous Congress, it now provides in part for the use of private insurance, and in this respect we are pleased that it does indeed recognize one of the strengths of the present system.

However, the total program contemplated in the bill H.R. 10028 is unacceptable. This is a program of catastrophic insurance for all—with benefits for medical services to begin after a family has incurred $2,000 of medical expenses, for hospital care benefits to begin after 60 days of hospital confinement. Coverage would be provided either under a public plan, administered in parallel with medicare, and subject to medicare conditions and limitations on payment of services, or under an elective employer plan providing private insurance for employees and their families. Such private coverage would be administered by the carriers. Underlying the public plan for catastrophic insurance would be basic coverage for low-income persons under a federalized medicaid program administered in the same manner as medicare and financed from Federal general revenues and State contributions. Providers and practitioners would be required to accept as reimbursement in full for their services only those amounts designated as payments from the plan.

In examining the need for such a program we observe that, in 1974, 135 million persons under age 65 had major medical insurance. This is the most rapidly growing form of health insurance in the Nation, and the trend for such added coverage is fostered by an increasing public awareness. Consequently, we must question the need to impose on the American taxpayer and consumer a costly universal Federal program of freestanding catastrophic health insurance.

We believe that the benefits under any health care program should be uniform, and our bill does provide for basic health care needs as well as catastrophic needs. Our bill recognizes that catastrophic protection should be a part of total comprehensive benefits. Free standing catastrophic coverage is made to appear attractive because it requires less financing, but this is because it is a program of very limited benefits and makes no provision for the fundamental health care needs of the majority. Catastrophic insurance alone is not a solution to the problem of meeting the health care problems of all persons. For this reason we have opposed such a measure.

There are additional objections to H.R. 10028 which we might point out, however. For one, the proposal will operate to enlarge the sphere of federally financed and controlled insurance coverage while severely reducing insurance in the private sector. Under a system of HEW certification of private insurance, private carriers will be induced to tailor their policies to provide basic coverage with limits adequate to meet the deductibles contained in Federal catastrophic insurance. This will have the net effect of transferring insurance coverage from the private sector to the tax-financed public program. It is easy to observe, moreover, that further Government invasion into the insurance field may be achieved through the simple device of reducing the catastrophic insurance deductible.

In our concern for erosion of the present health care system, we must look upon this program as an incremental approach to complete governmental domination of the health care system. The danger is real, and with accession of bureaucratic control the course of complete domination becomes more difficult to reverse.

The American citizen, as both taxpayer and patient would be ill-served by transferring the functions now performed by the private insurance system to a federally controlled and operated system.

In conclusion, we submit H.R. 6222 as the health insurance program best suited for fulfilling the national need. We urge your favorable consideration of H.R. 6222 as being based upon these principles on which any national health insurance program must be founded.

Mr. Chairman, we will be pleased to respond to any questions which the subcommittee may have. We wish again to state our appreciation for the opportunity to appear before you and present our views. Please be assured that it is our desire to be of assistance to the subcommittee as it considers this and other legislation affecting the health care of our citizens.

[AMA plan and prepared statements follow:]

A National Health Insurance Plan Designed by America's Physicians

1. WHY PHYSICIANS SUPPORT NATIONAL HEALTH INSURANCE

As the ones responsible for caring for patients every day, physicians know how essential quality medical care is to the health and well-being of an individual. They are also very much aware that the cost of health and medical care has become a financial burden for certain segments of our population. Even for those with substantial incomes, a long or serious illness can create serious financial problems.

These are the concerns that led physicians, through the American Medical Association, to develop their own national health insurance plan. It is called the Comprehensive Health Care Insurance Act of 1975 (H.R. 6222) and was introduced in Congress April 22, 1975.

2. THE UNDERPINNINGS OF THE PLAN

In formulating the plan, the physicians established a *comprehensive list* of medical and health services that would be available to everyone, incorporated a set of principles to assure *quality care*, and based the entire program on a *sound, realistic financing mechanism.*

Integral to the plan is the belief that federal financial help should be provided to those who need it most, and that everyone should be free to choose his or her own physician and health insurance plan. Further, physicians believe any program of national health insurance should be built on the best of the present system—a system which is already providing more and better health care to more people than in any other country.

3. HERE'S HOW THE PHYSICIANS' PLAN WOULD WORK

The program would provide a complete package of benefits essential to good health care, as well as to protect against the cost of catastrophic illness—without limits. Realistic preventive care benefits would also be included. Importantly, the plan is designed to keep red tape and bureaucracy to a minimum.

The actual health care protection would be furnished entirely by a private health insurance policy or plan. Coverage would be available through the present system of employer-employee group health insurance plans; or through a program for the self-employed and non-employed. Supplemental coverage would be available to those eligible for Medicare to raise the level of benefits to equal those of the physicians' plan. Individuals currently receiving Medicaid benefits would receive them through this new program.

Benefits

Under the physicians' plan, approved protection would have to provide payment of expenses for both basic and catastrophic health care needs. This would be true whether an individual participates in the employer-empoyee program, the program for the self-employed and non-employed, or the supplemental coverage for Medicare beneficiaries. All insurance plans offered would be approved by the respective states to assure that benefits met the comprehensive national standards.

Benefits for a 12-month period would have to include:

365 days of hospital inpateient care.

100 days of inpateint care in a skilled nursing care facility.

All emergency and outpateint services.

All physicians care (diagnostic, therapeutic, and preventive, regardless of where it is provided) and other health services.

All home health services.

All dental care for children.

Emergency dental care for everyone.

Ambulance service.

Institutional and outpatient psychiatric care.

Well-baby care.

Immunization.

Physical examinations.

X-ray and laboratory services.

Anesthesiology services.

Employer coverage

Most people would receive their health care protection as they do now—through the current system of employer-employee group health insurance. The employer would be required to offer the insurance but participation by the employee would be voluntary. At least 65% of the health insurance cost would have to be paid by the employer, the rest would be paid by the employee. Financial assistance will be provided for small businesses.

Self-Employed, Non-Employed, and Medicare-Eligibles

Individuals or families in these categories could buy qualified health care insurance. The insurance plan would have to meet the established national standards of benefits and policy conditions. The federal government would contribute toward the cost of the policy according to the individual's or family's ability to pay. The amount for a given year is measured according to how much the individual or family paid in income tax the preceding year.

For example, a family of four earning $4,850 a year would pay no income tax. Therefore, the federal government would pay the entire cost of the health insurance premium.

For a family of four earning $6,040 a year, the income tax would be $159. The federal government would pay 84% of the cost of the family's health insurance premium.

For a family of four with an annual income of $10,349, the income tax would be $891. For this category (and any individual or family paying more than $891 income tax), the federal government would pay 10% of the cost of the family's health insurance premium.

The financial assistance would be in the form of an income tax credit or a certificate to be given to the insurance company toward payment of the premium.

Unemployed

Unemployed persons, while eligible for federal or state unemployment compensation, would continue to be covered by their previous employer-sponsored insurance. Premiums would be paid by the federal government. If unemployment compensation expired before new employment, the government would continue to cover health insurance premiums for the rest of the year. At the beginning of the new calendar year, the individual would immediately be eligible for the non-employed subsidy program (described in previous paragraphs). Because of this provision, there would be no interruption in coverage.

Coinsurance

As with any program that offers as many benefits as the medical profession's plan, financial safeguards must be included, otherwise the program would be too expensive for the taxpayers to afford. In this program there would be cost-sharing in the form of coinsurance.

Although the amounts are small, cost-sharing between citizens and the government would help keep the total cost of the program at a reasonable level. It would help prevent policy holders from going to a physician "just because it's paid for" or entering a hospital "because it's more convenient."

Coinsurance would be 20% of the cost of all covered benefits—except for the poor. But in no case could coinsurance exceed $1,500 for an individual or $2,000 for a family, regardless of income. As soon as an individual or family reaches the limit on coinsurance, the catastrophic portion of the plan would take over.

Coinsurance would be 20% of the cost of all covered benefits, but not more than a specified ceiling limit related to income. The poor would pay no coinsurance.

This coinsurance maximum (the most an individual or family would pay) would be equal to 10% of the individual or family income after a "coinsurance deduction" has been subtracted. The coinsurance deduction is figured according to family size. For example, the deduction is $4,200 for a family of four. So if a family of four earns $10,000, the coinsurance limit (or total cost) for a 12-month period would be $580, or 10% of $5,800 (salary of $10,000 minus deduction of $4,200). The family would not have to pay more than $580 for all of the medical services provided in that year, even if there were expenses of a catastrophic size.

In no case could coinsurance exceed $1,500 for an individual or $2,000 for a family, regardless of income.

As soon as a family or individual reaches the limit on coinsurance, the catastrophic portion of the plan would take over.

4. WILL NATIONAL HEALTH INSURANCE REALLY SOLVE AMERICA'S HEALTH PROBLEMS

Unfortunately, no—because many of America's health problems do not have purely medical solutions. Many of these problems can be solved only when our society commits itself to eliminating the root causes, such as poor housing and sanitation, malnutrition, smoking, lack of exercise. A basic, and essential step in accomplishing this objective is the dissemination of good, sound health information to the public.

Over the years, America's physicians, through the AMA, have been deeply involved in health education. The AMA has on-going programs to educate the public about drug abuse, venereal disease, proper nutrition, and exercise.

The AMA is also working hard to increase the capability of our health care system by encouraging and supporting the expansion of the allied health professions and increasing the number of physicians. The AMA is particularly gratified that the total enrollment in U.S. medical schools has increased from 32,500 in 1965 to 53,000 in 1975. An equally important development is the increasing numbers of medical students entering the primary care areas of family practice, internal medicine, obstetrics and gynecology, and pediatrics. In 1973 alone, nearly 50% of the graduating students entered residency training in these areas.

The AMA has also been a very active and positive force in the passage of constructive health and medical care legislation for the public. It has strongly supported such federal legislation as maternal and child health programs; protection of human beings in medical research; drug abuse education; medical devices safety standards; cancer research; assistance for allied health personnel, public health personnel and nurses training. In addition, the AMA has authored and introduced legislation to develop community emergency medical services programs, to improve rural health care delivery, and to upgrade health care for American Indians.

Many years ago, physicians, themselves, pioneered peer review programs, and set up safeguards to ensure that all patients receive quality medical and health care.

Even though our present system provides more and better health care to more people than in any other country, physicians are aware that the American system is not perfect. And they are as concerned as anyone about its improvement. The Comprehensive Health Care Insurance Act is only one of many AMA programs that represents the physicians' active campaign to improve health care and its delivery in America.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION RE: NATIONAL HEALTH INSURANCE

(By Max H. Parrott, M.D. and Richard E. Palmer, M.D.)

Mr. Chairman and Members of the Subcommittee: I am Max H. Parrott, M.D., President of the American Medical Association. I am a practicing physician from Portland, Oregon. With me today in presenting Association testimony on this important subject of national health insurance is Richard E. Palmer, M.D., President Elect of the American Medical Association. Doctor Palmer is also in practice and is from Alexandria, Virginia. Accompanying us is Harry N. Peterson, Director of our Department of Legislation.

Mr. Chairman, we are pleased to have this opportunity to appear again before you to express our views on national health insurance. The subject of this legislation has been raised many times during the past three Congresses. Once again national health insurance is under close scrutiny by interested Congressmen, Committees, Administration officials, and the public.

Earlier this year this Subcommittee held special hearings to obtain views from selected individuals. Our Association, in the early part of this year, submitted to you a written statement on this subject in response to the Subcommittee's invitation. The current series of hearings should serve to update information before the Subcommittee, Other hearings are expected to be held by other Committees of Congress and, in fact, such intentions have been announced.

The extended discussion on national health insurance which has taken place during the past years has been beneficial in many respects in analyzing the issues and in evaluating the impact upon society.

We have observed a shift in attitude toward such a national program with an increased awareness and concern on the part of most interested parties as to the magnitude of the problems involved. These problems have been brought into better focus as a result of evidence of the effects of governmentally administered and controlled programs both here and abroad.

Our national priorities have also shifted because of the effects of the chaning economy, and the devastating effects of inflation on all segments of our society.

The public has expressed among its major priorities a concern with inflation, with the state of the economy, and with crime. National polls have indicated that national health insurance is of low concern.

During this same period of time significant changes have taken place in our health system through increased manpower programs, increased facilities construction, increased levels of private health insurance coverage, and a variety of other programs. There is fuller realization and acknowledgment that this country's health system—under attack by many in the course of the NHI debate—is indeed superior to any other in the world.

Mr. Chairman, we will amplify on these points as we proceed in our testimony.

Improvements in our health system are continually occurring, and the system is increasingly effective in responding to the needs of our society. Individuals who have recently testified before you have urged deliberation and caution in considering any national health plan. This will assure that our excellent system will continue to improve and will not suffer the stifling effects experienced in other countries.

When considering a national plan for this country it is necessary to take cognizance of the strengths of our method of health care delivery. I would like to review briefly some of those strengths with you at this time.

First, American medical service and medical technology have developed at an unparalleled rate, along with American scientific achievement in general, since World War II. Presently in this counrty there is more and better medical technology than anywhere else in the world. And that technology has been fostered and achieved in the absence of a national health insurance program.

Second, there are more physicians being graduated from medical schools at this time than at any other time in our history. The estimated number of graduates for this year is nearly 13,000, a 72% increase in 10 years. In addition, approximately 50% of those entering graduate medical education (specialty training) are now in medical specialties considered as primary care—a goal which was not expected to be achieved for several years (see attachment 1). This is being accomplished in the absence of national health insurance or federal controls.

Third, more medical schools have opened in the past ten years than were opened in the previous twenty years. We now have 114 medical schools as compared with only 88 in 1965 (see attachment 2). Many of these schools are emphasizing primany care and are located in non-metropolitan or physician shortage areas. Thus, too, has been done in the absence of a national health insurance program.

Fourth, statistics show that presently the private sector has made available to the population basic health insurance benefit policies covering 80% of the total population. In addition that same private sector provides catastrophic benefits for 3 out of every 4 persons in this country. The bulk of the remaining population has access to Medicare/Medicaid. A very small percentage represents people who, unfortunately, do not now have such insurance. Of significance, we note that while there is an increasing amount of private insurance, the total percentage of health care expenditures for private insurance benefits for the under-65 population has steadily increased from 1966; also, total out of pocket personal expenditures (which include premium payments) have decreased during that time. Moreover, this massive private health insurance coverage has occurred without stimulus of a national health insurance program.

It is also necessary to point out that if we had adopted programs similar to those of other countries our present strengths would have been compromised and jeopardized.

Mr. Chairman, these great strengths which we see in the health care system of this country are the ones upon which we believe it is most appropriate to build any program of national health insurance. It is both reasonable and obvious that these aspects must be accentuated rather than adopt a program suggested by some which not only would impose a system of Federal administration upon our health system but would also attempt, for some reason still unclear to us, to "restructure" the entire system.

We do, of course, recognize that there are some weaknesses within the present health system. But we would hasten to point out that weaknesses are in the process of being rectified by our present responsive system without the need for a national health insurance program.

Manpower shortages are being overcome (surpluses, in fact, have been predicted for the near future by responsible government officials), alternative delivery systems are under experimentation, new types of providers are being utilized on an increasing scale, greater health education is being carried on by many groups, and new public awareness of the impact of total environment upon health is being aroused.

However, one significant problem which does remain, and which appears to use as a primary concern of the public, is the one of financial access to care, particularly in view of advanced medical technology and increasing health care costs, as well as the state of our economy.

We have all been made aware of individuals, or their dependents, who have need of medical care but who have had inadequate insurance for both basic and catastrophic benefits.

It is this type of example which had made us all fear for the financial consequences of illness. Financial hardships do occur, and provisions must be made for their occurrence. But these occurrences must not be used as the justification for a national program to restructure an otherwise viable, responsive, vital and highly competent system.

As you hear testimony from advocates of those programs which would attempt to restructure the system as well as to provide a financing mechanism, I would urge you to keep in mind not only the foregoing essential considerations, but also the following basic thoughts concerning medical care in America today.

First, the need for catastrophic coverage is to assure that if such expenses do occur the individual will be able to pay from a source other than his own pocket. Nevertheless, this insurance for most people under 65 in reality is only *assurance* for peace of mind since, for most, the catastrophic occasion will never occur. The major need remains access to full care.

Second, preventive health care, touted by many supporters of other bills as achieving a superior state of health if enacted, is limited in its effectiveness under any health insurance program. National health insurance *cannot* correct many conditions leading to serious illnesses and to suggest otherwise amounts to overpromise. For example, how would any physician stop his patient from smoking? What will convince anyone not to overeat or not to pursue an improper diet? Who can be forced to exercise? What will be done to assure adequate housing, clean air, proper working conditions, a healthful environment? What about boredom, indifference, depression, lack of family attachments? Who will stop drug addiction and alcoholism? What about injuries and deaths caused by accidents? We could continue to enumerate many other issues which, whether generally recognized or not, are part of preventive health care and which have a definite, direct bearing upon life styles, quality of life and of health, but which cannot be ameliorated by any national health insurance.

Third, it must be pointed out that one of the very basic reasons for present concern over the high cost of care can be directly traced to the success of medicine in recent years in its development of new technology. The elderly live longer today because of better medical technology. The seriously ill or injured are kept alive and eventually returned to normal life through the intervention of more highly skilled personnel and more complex equipment. Organs are transplanted, and people are able to carry on their lives. Today we treat and maintain the chronically ill and the seriously ill and injured beyond what was even imagined twenty or thirty years ago. In addition health facilities are expensive because of the necessity to comply with present statutes and regulations intended to foster quality care. Labor, equipment, and supply costs are higher. Although some costs might be reduced through a system of strict rationing, we must pose the question as to whether Congress would desire such a system in the expense of continued development and application of medical technology.

All of these points which I have reviewed with you strongly militate against a restructuring of our present system.

With these concepts in mind, I would urge you to look to the fundamental issues in the proposed national health insurance plans—methods of financing and administration.

In these two elements the plans vary considerably.

Some plans would tax payrolls through Social Security taxes to fund a program administered and controlled by Social Security. Others would more realistically rely upon the present strong points in our system by requiring employer coverage and insurance carrier administration in the private sector.

This latter type plan recognizes the important role of the private sector as well as the administrative limitations and shortcomings of Federal bureaucracy. It also recognizes the fact that administration of a national health insurance program is better performed in the private sector. Administration in the private sector is more realistic when one considers the mounting evidence of problems arising in national programs which are prototypes for proposals now advanced involving government administration.

We need only call attention to European national health insurance programs as examples. When their central government took over the responsibilities for financing and administering programs, the growth and development of facilities and technology were "frozen" at the level at which central government took control. Since that time the governments have been faced with increasingly antiquated facilities, with a growing dissatisfaction with the government system by both providers and patients, with an exodus of trained personnel to other countries, with increasing tax liability, with increase in costs, with waiting lists of one or more *years*, and with inability of government to cope with "rationing" of health care. And it must be remembered that these problems have occurred in countries which are, as compared with the United States, small in area, compact, and homogeneous—factors which should really help to assure success—and where the population is inclined to look to the central government for assistance in many areas.

In our country, the program which comes closest to an example of a national health insurance program for the public is Medicare—a program which has benefited the elderly. However this program has been characterized by over-zealous bureaucractic control. In fact, its method of administration cautions against adopting any such similarly administered program for the general public.

For example, for many of the aged Medicare represents their only insurance protection. The program was, because of rhetoric engaged in at the time of its passage, cast in the light of full coverage. Medicare today, however, in fact provides less than one-half of the beneficiaries' health costs. The limitations of the law, together with interpretations by HEW, have restricted payment benefits. In addition, copayments and deductibles which are part of the program have increased annually (e.g., as to the hospital deductible, from $40 in 1966 to $104 in 1976). Part B premiums have also increased.

Providers themselves have been affected by bureaucratic interpretations which have often discouraged provider participation rather than encouraged it. Recent improper regulations have included the utilization review regulations, the economic index controls, the MAC impositions and the arbitrary hospital reasonable cost limitations.

If Medicare is the example of what a national health insurance program will become in this country, then we can expect the government, on one hand, to provide a program creating the appearance of a broad and attractive package of benefits, but on the other hand, to limit the benefits by paying less than the true value of services provided, by establishing budgetary limitations on expenditures for all categories of services, by determining patient coverage based on fine lines of administrative regulations, by requiring extensive paper justification of every service, and by allowing administrators to "rewrite" sections of the law.

Is it reasonable to believe that with a national health insurance totally administered by the government the same experience will not recur? Is this what the American people really want?

We would further draw your attention to the recently issued report of the General Accounting Office entitled "Performance of the Social Security Administration Compared With That of Private Fiscal Intermediaries in Dealing With Institutional Providers of Medicare Services". The conclusion stated in that study is, in the words of the GAO, expressed in the following:

> GAO compared performance and cost of the Division of Direct Reimbursement with that of four contract intermediaries. It found that the average cost of a bill processed by the Division in 1973 was greater than that of the four private insurance companies. Higher salaries and lower productivity appear to be major reasons for the higher costs of the Division, which, unlike the private intermediaries, had no production standards. Financial reports required of private intermediaries were not required of the Division.

As a final cautionary note, we would urge you to consider the inflationary impact upon the economy of governmentally financed and administered program. We are all aware of the present difficulties through which our economy has been passing during the past two years. The Federal budget has been near the breaking point with a scope of deficit spending which is staggering in comprehension. Federal spending has arrived at the point at which the public is unable to withstand the two-pronged assault on it of inflation caused by deficit spending and of high taxes imposed in order to support Federal programs.

Within the health care sector of our economy we can identify certain causes for rising costs—better but more expensive technology, care of chronic conditions, expensive liability insurance, and higher labor and supply costs. However, these are only partial reasons. In order to appraise the factors leading to rising costs in health care, this Association is convening a national Commission on the Cost of Medical Care to be composed of individuals representing various sectors of the health care field and of the public.

In the meantime, however, Mr. Chairman, in order not to increase inflationary pressures and deficit spending, nor to hinder medical technology and the forward strides taking place in health care development, we must caution against any Federally controlled and administered national health insurance program. Should we rush into such a system, the result will be a decrease in quality care and in availability.

We would also caution that no national health insurance system can achieve its goals without the support and commitment of providers of services. Artificial and unrealistic limitations on reimbursement or interferences with the practice of medicine will curtail availability of service and defeat the purposes of the program.

At this time I would like to call upon Doctor Palmer to continue with our testimony.

STATEMENT BY DOCTOR PALMER

Mr. Chairman and Members of the Subcommittee: In the past few years, a great many proposals for national health insurance have been introduced in the Congress, all with a common claim of increasing the availability of health care to all Americans regardless of income. Many volumes are filled with the testimony of advocates and critics of the various plans submitted, and countless appeals have been made before committees of the Congress and in public forums urging the adoption of one plan or the other.

In pressing for the adoption of any particular proposal, sincerity must not be confused with objectivity. We cannot afford to have a program of such importance fail.

We must avoid the mistake inherent in proposals such as H.R. 21 which would lock medicine into a a rigid, monolithic, no-choice bureaucratic system. Such a creation would be impossible to reverse. It would be an undertaking full of promise but empty of fulfillment. Establishment of cost control through fixed budgets including arbitrary fee schedules would result in curtailment of care and discourage participation by providers. A look at the current trouble of the British health care system impels a close re-examination of the alleged need for such drastic action, as is embodied in H.R. 21. In our our opinion justification for such a program is totally lacking.

The health care system is this country is a pluralistic one—a composite of various private initiatives and public programs. It is a system which encourages innovation and competition by providing incentives for organizational change and offers opportunity for improvement of quality care.

At this time I would like to restate a point made in our testimony to the full Committee in April, 1974: "The fact is that more people are receiving more and better medical care from more and better trained physicians in more and better equipped facilities than ever before in history" in this country.

Poll after poll confirms that people are generally satisfied with the type of health care they personally receive. It would indeed be surprising to find such consensus on any other issue or subject having such personal impact on individuals.

The public interest would be better served if we examine the goals of NHI within the context of the existing system and direct our energies toward perfection of this system in meeting the health care needs of all Americans.

Needed improvements can be brought about without gambling on a whole new medical health system whose effects and efficiencies, in the main, are unpredictable. We offer our plan for maximum health services for all persons through comprehensive insurance protection under a proven system which provides the finest health care in the world, and which can be financed in the private sector with a minimum of federal support. This is the "Comprehensive Health Care Insurance Act of 1975" (H.R. 6222).

H.R. 6222 would establish a program to assure that every person has equal access to high quality medical and health care regardless of ability to pay. For the poor and the affluent alike it provides identical coverage and includes protection against both the ordinary and catastrophic expenses of illness that an individual or family might encounter.

Coverage would be provided for all inpatient and outpatient hospital care, 100 inpatient days a year in a skilled nursing facility, and all home health care services. It also provides: full physician services, including all medical care provided under his direction; a full range of preventive services, including physical examinations, immunizations and inoculations; well-baby care; X-ray and laboratory services; ambulance services; and full psychiatric care. Children under age 7 will be fully covered for dental care, and this age limit will be raised each year until all persons under the age of 18 are covered; adults would be covered for emergency dental care.

Cost-sharing will apply as a safeguard against abuse, but will apply in moderation so as not to deny benefits to persons in need of care who cannot meet such costs. There is no deductible in our plan—no fixed amount is required to be paid before benefits begin. Benefits will begin immediately, with coinsurance set at 20% with a limit on the amount of coinsurance that any individual or family will be required to pay in a year. The limit will be related to income. The poor, however, will not pay any coinsurance.

Most Americans are currently covered by employment-based insurance, and the premium is paid in full by the employer or shared between employer and employee; the total cost is thus paid in the private sector and without government involvement. H.R. 6222 mandates the employer to offer coverage for employees and their families, thereby continuing a method of protection with which they are all familiar and which can be readily put into operation. The mandate gives legislative assurance that the full coverage will be provided, that the employer will pay at least 65% of the premium and, accordingly, that the employee will have only a limited participation in the premium cost.

Those who are unemployed or poor will be entitled to federal participation in the premium but they—like all others—will still have a choice of private coverage—an insurance policy, a Blue-Cross/Blue Shield plan, a group prepayment plan (including HMO), or any other plan meeting the program standards of adequate coverage. The amount of federal contribution would be scaled according to income of the insured—and the government would pay the full premium for the poor. On the same basis, federal participation would assist Medicare eligibles in obtaining supplemental coverage to bring their benefits up to the level contemplated in the new insurance program.

Simple mechanisms built into the program facilitate the government's premium participation without resort to a cumbersome means test. A premium participation table enables the individual to assess readily the amount to which he is entitled. He may buy his insurance, pay the full premium and claim the government share as a credit against tax on his income tax return. Or he may arrange to pay only his share of the premium, if any, prepare a claim form, and have the carrier bill the government for the premium balance.

Most Americans believe that the role of government financing in health insurance should be directed toward making quality care accessible to those who cannot afford to meet the expenses of such care. This is an underlying precept in our program of private insurance through employment—financed primarily in the private sector—and premium assistance by government for the poor and the elderly. It is in sharp contrast to the financing in H.R. 21 that would impose on our tax system—already strained—the burden of some $50 billion in new social security taxes and the matching from general revenues of an additional $50 billion in order to support a federally controlled and administered health care system under which all services would be supplied by providers and professional practitioners under contact to the government.

There is no basis for assuming that health care financing can be better or more economically administered in the governmental sector than in the private sector. On the contrary, government administration has been shown to be more costly. We agree with a former Secretary of HEW that elimination of the profit factor, through the Social Security handling of health insurance finances, will not bring economies and efficiencies; the financing of health care is too important to the American people to turn over to a federal bureaucracy.

If we allow Federal administration, we risk creating a national program which is unresponsive to particular needs and lacking in sufficient stability and innovation. We need a health care system that has room for and will reinforce the strengths of private initiative, not one that will stifle them under piles of paperwork and federal regulation. It is our firm conviction, therefore, that any national health insurance program should be administrative through the private sector.

Public opinion, as adjudged in various polls, does not perceive medical service to be a major problem area. This is the substance of the Louis Harris poll, commissioned by a Senate Subcommittee, which indicated that whereas 64% of the sample identified inflation as our nation's most serious problem, health care rated 15th, or next to last in the list, with only 3% of the respondents putting emphasis on this. Inasmuch as any of the proposals for extensions of federal subsidies for medical service are inevitably inflationary to some degree, one wonders about the advisability to further aggravating this most serious problem in order to attack a problem of much lesser magnitude.

If in view of the Congress, an urgent need for national health legislation exists, we commend for your specific approval H.R. 6222, which would preserve the flexibility of our medical system, and build on the real accomplishments of American medicine. It stresses the major contribution made by the private sector of the economy and takes advantage of private institutions and industries. It attempts to hold to a minimum its demands upon government, both for tax dollars and for the inevitable controls that go with them and does not thrust upon the government a tremendous program of health spending to be financed primarily through new taxes.

We see, on the other hand, in some of the other proposals now before the Congress, elements which threaten the existing system of health care delivery and the high quality of care it affords. We shall touch on only a few of these.

We have already indicated our strong opposition to H.R. 21. We also strongly oppose a public utility approach to health care delivery as conceived in H.R. 1. Newly created entities—Health Care Corporations (HCC's)—would be operating under franchise of the State Health Commission (SHC), in designated areas within a state, and would provide services directly or through affiliates within their franchised areas. Each SHC would be under mandate to divide the state into HCC areas and blanket the state with HCC's. The SHC would also have rate making authority. In addition to the special federal subsidies for the development and operation of HCC's, provision is made for special premium subsidies for HCC enrollees. In the interest of good medical care, we have advocated a policy of pluralism which affords an individual or family a variety of health care delivery methods, and a choice of the kind of care they will receive. We must therefore reject the discriminatory federal funding in support of a single method of health care delivery. We reject, also, as undesirable and unnecessary, the state franchising of health care operations and public utility regulation.

H.R. 1 specifically requires that services of certain physicians (such as radiologists and pathologists) be paid as hospital services, thus making them subject to the institutional rate making provisions. This is highly objectionable. Any plan should properly recognize the physician's professional service as being distinct from hospital services, and any provisions for institutional reimbursement should not be interpreted to include the professional services irrespective of the setting in which the professional services are provided. This differentiation from hospital services should apply to physicians services under any bill, including H.R. 6222.

Another bill, H.R. 10028, (identical with S. 2470, the Long-Ribicoff Bill) emphasizes catastrophic coverage. Revised from its form in the previous Congress, it now provides in part for the use of private insurance, and in this respect we are pleased that it does indeed recognize one of the strengths in our present system.

However, the total program contemplated in the bill H.R. 10028 is unacceptable. This is a program of catastrophic insurance for all—with benefits for medical services to begin after a family has incurred $2,000 of medical expenses, for hospital care benefits to begin after 60 days of hospital confinement. Coverage would be provided either under a public plan, administered in parallel with Medicare, and subject to Medicare conditions and limitations on payment of services, or under an elective employer plan providing private insurance for employees and their families. Such private coverage would be administered by the carriers. Underlying the public plan for catastrophic insurance would be basic coverage for low-income persons under a federalized Medicaid program administered in the same manner as Medicare and financed from federal general revenues and state contributions. Providers and practitioners would be required to accept as reimbursement in full for their services only those amounts designated as payments from the plan.

In examining the need for such a program we observe that, in 1974, 135 million persons under age 65 had major medical insurance. This is the most rapidly growing form of health insurance in the nation, and the trend for such added coverage is fostered by an increasing public awareness. Consequently, we must question the need to impose on the American taxpayer and consumer a costly universal federal program of free standing catastrophic insurance.

We believe that the benefits under any health care program should be uniform, and our bill does provide for basic health care needs as well as catastrophic. Our bill recognizes that catastrophic protection should be a part of total comprehensive benefits. Free-standing catastrophic coverage is made to appear attractive because it requires less financing, but this is because it is a program of very limited benefits and makes no provision for the fundamental health care needs of the majority. Catastrophic insurance alone is not a solution to the problem of meeting the health care problems of all persons. For this reason we have opposed such a measure.

There are additional objections to H.R. 10028 which we might point out, however. For one, the proposal will operate to enlarge the sphere of federally financed and controlled insurance coverage while severely reducing insurance in the private sector. Under a system of HEW certification of private insurance, private carriers will be induced to tailor their policies to provide basic coverage with limits adequate to meet the deductibles contained in federal catastrophic insurance. This will have the net effect of transferring insurance coverage from the private sector to the tax financed public program. It is easy to observe, moreover, that further government invasion into the insurance field may be achieved through the simple device of reducing the catastrophic insurance deductible.

Complexities in present federal insurance administration will be compounded as different conditions and methods of payment become applicable with respect to the individual who has basic private insurance and government catastrophic insurance. The insured as well as the health care provider may not learn until after the services have been performed whether such services will be reimbursable under the conditions of the private carrier or the government. The complexities of the bill will cause needless confusion.

In the same vein, there are ominous implications in the fact that methods of reimbursement will differ according to whether an employed person is covered for catastrophic insurance under an employer plan or under a public plan with its specific reimbursement limitations. We must object to a further extension of the unfair and arbitrary Medicare reimbursement levels for physician services.

In our concern for erosion of the present health care system, we must look upon this program as an incremental approach to complete governmental domination of the health care system. The danger is real, and with accession of bureaucratic control the course of complete domination becomes more difficult to reverse.

The American citizen, as both patient and taxpayer, would be ill-served by transferring the functions now performed by the private insurance system to a federally controlled and operated system.

In conclusion, we submit H.R. 6222 as the health insurance program best suited to fulfilling the national need. We urge your favorable consideration of H.R. 6222 as being based upon those principles on which any national health insurance program must be founded.

Mr. Chairman, we will be pleased to respond to any questions which the Subcommittee may have. We wish again to state our appreciation for the opportunity to appear before you and present our views. Please be assured that it is our desire to be of assistance to the Subcommittee as it considers this and other legislation affecting the health care of our citizens.

Mr. ROSTENKOWSKI. Thank you, doctors.

In your testimony you call attention to a number of favorable developments in health care and health insurance.

Dr. PALMER. The number?

Mr. ROSTENKOWSKI. You call attention to a number of favorable developments in health care and health insurance. You point out that each of these improvements has been achieved in the absence of national health insurance.

You almost sound as though you do not see any need for national health insurance. Yet, you do have a program. Why do you think there is any need for national health insurance?

Dr. PARROTT. Well, I would start out, Mr. Chairman, by pointing out that there are a number of our constituents who see no need for a national health insurance program. However, the policy of the association is based on the decision of the majority of the people we represent, some 200,000 physicians in this country, and the majority of them feel that there is some form of national health insurance which is problematical or inevitable. Under those circumstances, then, our pleading is that it be the proper type of national health insurance and that, I think, was the point that Dr. Palmer was making during the latter part of his testimony.

Do you have anything to add?

Dr. PALMER. I think not. But I do think, Mr. Chairman, you have to recognize that our constituency is probably much like yours. We have every political shading of individual in our constituency and I am sure you do, too. The center of that distribution curve, I think does favor some form of——

Mr. Rostenkowski. What are some of the reasons that an element in your association feel the need for medical health insurance? What are the reasons that this element is giving?

Dr. Palmer. I think it is perfectly obvious that there are people who for one reason or the other do not have either access to medical care or they do not have physical access or they do not have the financing that would enable them to receive medical care. Albeit, this number is small, but there is an element in this country that simply does not not have the money to get health care, and they do not have insurance. So, for that reason, we do believe that every American should have the opportunity to have access, at all times, to high quality medical care.

Dr. Parrott. Particularly if he needs it. One of the problems is, of course, the method by which the 15 or 20 percent of the population are cared for under the medicaid program which has been a big problem. The middle group of people are insured; I think their main concern is, as we have mentioned, catastrophic. But there is—the whole situation can be catastrophic for the destitute and poor and near poor, and we feel that one of the things that we really have not gotten the right handle on to date, Mr. Chairman, has been the way in which the people who fall into that category, the category of the poor and near poor, is handled. I would like to take the opportunity to ask Mr. Peterson to make some comments, if it is OK.

Mr. Rostenkowski. Fine.

Mr. Peterson. In answer to your question, Mr. Chairman, you note the purpose in the statement to show the recent developments and improvement in the health care delivery system was made to emphasize the fact that national health insurance, as a separate program, is not necessary in order to accomplish what is presently being done in the absence of national health insurance.

Now, in response to your question, then, our statement also points out that one need that is shown and can be addressed by national health insurance is the one of financial access to health care. It also points out that this occurs, in particular, because of the rising costs in the economy generally, and the resultant need to assure the financial support for care.

Mr. Rostenkowski. Do you think there is a possibility those improvements came about because there is inevitably a national health insurance program that will be fostered by this Congress or the subsequent Congress?

Mr. Peterson. Well, I think that these developments have certainly occurred during the period of discussion of national health insurance. No question about that. There are many programs that have been fostered by the Congress which have been very beneficial in aiding development of these programs. For instance, the extensive manpower developments have certainly been brought about by congressional assistance to the medical education which was generated through the congressional programs initiated, I think, in 1963.

These have been very beneficial in increasing the number of medical schools, increasing the number of students, and graduates. If I may, I might just illustrate some of the figures that we feel are dramatic and shown in the table as the second attachment to the statement.

For instance, going back, using figures from 1955, to 1965, and to the current 1975 figures, then, I would just show the total enrollment of medical students in medical schools. In 1955 there were approximately 28,000; in 1965, there were 32,000; and that is roughly 4,000 increase in 10 years.

In the last 10 years, the increase has been to 54,000 which has been about 22,000 increase in number of students in medical schools.

I would indicate that this along with other developments has been occurring, certainly with the stimulus of congressional programs.

Mr. Rostenkowski. Thank you, Mr. Peterson.

Mr. Duncan will inquire.

Mr. Duncan. Thank you, Mr. Chairman.

I would also like to welcome all of you to the committee. Do you think that a program of national health insurance should be phased in, if there were to be one?

Dr. Parrott. Yes, sir, this has been our contention, but you have to kind of qualify by what you mean by phased in. We have been approached by people in our own groups and other groups about the incremental approach which I presume is a way of phasing in.

But you have to understand clearly, or we think we have to understand clearly, what the increment means. There has to be a goal.

Mr. Duncan. But I was going to ask you that. If you do believe in the incremental approach, what should we start with?

Dr. Parrot. Well, I am not particularly intrigued with the incremental approach.

Mr. Duncan. You think it ought to be all at once?

Dr. Parrott. It would be impossible, but I think what we have asked be done is to build on what we have. You have a medical delivery system now that is operating and you cannot do a complete flipflop without running great dangers as to cost containment and as to quality. Also, some danger as to access, too, because wherever you get an effect upon quality and cost, you have an effect upon access.

I would prefer that that be kept in mind because the incremental approach, if not directed toward a balanced goal, could be as dangerous as taking a bad practice in toto.

Do you have anything to add?

Dr. Palmer. No, I think you have covered it.

Mr. Duncan. Do you think the Federal Government should take an interest in the malpractice problems that the medical profession is facing today?

Dr. Parrott. No, sir.

Mr. Duncan. You recommend it be left entirely to the State governments?

Dr. Parrott. It is an insurance problem and it has traditionally belonged to the States. That is not to say it is not a big problem and doesn't have national impact. We are cognizant of that.

Some 300 tort reforms were made during the past year which, considering the fact that most statehouses are heavily covered by attorneys as members of statehouses, and the fact that there was some resistance to tort reforms in the legal profession, this was an accomplishment basically of the State medical societies with the help of the national medical association, the American Medical Association, through its leadership with the States.

That was considerable, but it does not really relieve our real crisis at this moment which is, of course, the crisis of the cost of premiums. It doesn't look to us that there is any quick relief for that.

This has an effect upon manpower, sir, and this is the thing that worries us the most. How are we going to get our young men and women into practice next May when they come out of their internships and residencies?

We are working on that now, we are trying to get a State level approach as to which seems to be the best way to go at the present time.

Mr. DUNCAN. How would you suggest we meet the problems of maldistribution in order to assure every person access to quality medical care.

Dr. PALMER. Mr. Duncan, I think that under our present system we indicated that the primary care residencies had increased manifold. At the present time, I recall we have some 1,280 approved programs in this country for training of primary care physicians. This embraces about 8,800 physicians in training.

We have been a firm supporter of the National Health Service Corps program which we think is a splendid program. This shows every bit of evidence that it will be successful. It has been successful.

Backing this up, the American Medical Association has itself instituted a program which we have euphemistically called "Project U.S.A." which is a recruiting project for obtaining practicing physicians who are willing to relocate themselves for short periods of time to relieve young men who are in the National Health Service Corps.

We believe that with the National Health Service Corps program placing men in areas of need where they are wanted by their local medical societies, that, ultimately, a significantly high percentage of those people will stay in the community, work and live there and become part of the community.

Mr. DUNCAN. I want to ask one other question and my time is about up if not already up. I visited recently some health clinics in some very remote rural areas in eastern Tennessee and a nurse ran the clinic and I think a physician came by about 1 day a week and went over her records.

What are your thoughts on that procedure or the nurse practitioners, whoever they are called. They seem to be doing a tremendous job in serving the people.

Dr. PARROTT. Yes, sir. I come from a similar State where there are large reaches not serviced by physicians and the use of triage arrangement seems to us to have—we have talked about this, triage, transportation and treatment, and it would seem in those kinds of locations which either economically can't support a physician or group of physicians, because of remotness, would have to be served by some form of a triage group maybe headed by a nurse practitioner or some other physician's assistant under supervision of a physician from a central area.

This is one way in which the tremendously large areas could be served. However, there are a lot of fairly substantial towns in rural areas that don't have physicians that probably could economically support physicians.

Mr. Duncan. I am aware of that, yes.

Dr. Parrott. Well, we have those, too. The best way that this can be approached is to build, as Dr. Palmer said, the incentives to get men out there. We have known for some time that it takes primary physicians, and is takes groups of primary physicians because a solo practitioner in a rural setting has no relief whatsoever.

Mr. Duncan. You can give all the incentives in the world for some remote areas that you are talking about and I am talking about, and you could never get a physician to go back there, but you could get a nurse to go in there. My time has expired, but I would like to go further with you on this.

I do thank you very much for coming.

Mr. Rostenkowski. Mr. Burleson?

Mr. Burleson. Thank you, Mr. Chairman.

I join with you and others in welcoming these distinguished witnesses who have appeared before us on a number of occasions before.

This is not directly on the subject of national health insurance at the moment although it is related.

Do you expect PSRO, when it is up to its full potential—whatever that is—to have the effect of reducing medical care?

Dr. Palmer. Of reducing, you say?

Mr. Burleson. Yes. Or what do you think the effect is going to be when it is fully implemented?

Dr. Palmer. Mr. Burleson, this is an imponderable question, almost. As you well know, the American Medical Association has for years supported and we firmly believe in the concept of peer review.

We, in our early medicredit bill, if you recall, there was a provision for peer review organizations. The mechanism was there whereby physicians would, themselves, review the quality of care given. We have been doing this for year, through committees, peer review committees, mediation committees at medical society levels, so we firmly believe in this.

Yes; I do think that a mechanism of peer review can be effective in producing high quality medical care.

I have grave doubts about the PSRO as it currently exists, and, Mr. Burleson, we fully support the 19 amendments that we know have been introduced into the Congress for action; I hope this action will be forthcoming in the near future.

Mr. Burleson. I think you——

Dr. Parrott. I would also like to add, that the American Medical Association did coordinate a program with the specialty associations of the country to create criteria in helping implement the PSRO law. Now, you must understand, of course, that there are a great number of our constituents that have doubts about that law. We would also like to see some of the amendments enacted, since PSRO is going to have an effect upon quality, and the state of the art has to be built around that and its provisions. They don't exist now, of course.

Mr. BURLESON. Thank you very much.

Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Cotter will inquire.

Mr. COTTER. Thank you, Mr. Chairman.

Dr. Palmer, you state that your bill would involve a minimum of Federal support.

Dr. PALMER. I didn't quite understand you, Mr. Cotter.

Mr. COTTER. You stated your bill would involve a minimum of Federal support, dollarwise. Do you have a price on your program?

Dr. PALMER. We could give you a ballpark figure. I hope we would not be held to it.

We figure that—a preliminary study would show, we feel, that if a bill had been in effect during this past year, that the premium cost would be in the neighborhood of $45 billion.

Mr. COTTER. $45 billion?

Mr. PETERSON. Let me correct that just one moment.

Dr. PALMER. Go ahead.

Mr. PETERSON. Can I amplify on that, please?

Mr. COTTER. Certainly.

Mr. PETERSON. The figures with respect to the cost of the program, Mr. Cotter, have some variables, of course, that are built into it because of the heavy emphasis on the Federal aid in the program to those people who are poor and would need assistance. So, at the present time because of the way the economy is fluctuating and depending upon the rate of unempoyment that exists at any particular time, to establish a figure we have made some preliminary estimates based upon variables of unemployment ranging from 5 percent to 10 percent unemployment rates. Based upon this, the cost to the Federal Government, if I can use the term of net cost to the Federal Government, because of certain reductions in the medicaid program that would ensue, and certain adjustments that would be made in the tax structure and would eliminate some medical deductions that ar taken at the present time, offsetting these figures, then, we have considered that the net cost to the Federal Government at a 5 percent annual unemployment rate would be approximately $3.6 billion.

Mr. COTTER. $3.6 billion?

Mr. PETERSON. And $4.9 billion at a 10 percent unemployment rate.

Mr. COTTER. 10 percent unemployment, $4.9 billion?

Mr. PETERSON. That is correct.

Mr. COTTER. Does this take into consideration the loss of revenues because of tax deductions and so forth?

Mr. PETERSON. Yes, it does.

Mr. COTTER. This is a net figure then?

Mr. PETERSON. That is correct. These are preliminary figures and we have thm under review.

Dr. PARROTT. The figure Dr. Palmer gave you had to do with the premiums being paid. That is old money and what the figure was was a total cost if you take up all the old money. What Mr. Peterson is saying is that that amount of new money would be involved.

Mr. COTTER. I was wondering if you care to comment? You know, we have a lot of witnesses here in the past week or so. Their position is that we are already spending something like $118 billion a year in medical costs and actually the additional costs of going into a complete comprehensive program set forth by Congressman Corman and Senator Kennedy would not cost us any more, but merely what you would have is a redistribution of the dollars.

Do you have any thoughts on that?

Dr. PALMER. Mr. Cotter, it seems to me that last year when Dr. Roth was here, he made, I thought, a very good point. Dr. Roth said, "If you come to me as a patient and you pay me $10, it has cost you $10 and I have earned $10. But now, if you give that same $10 to Washington to launder and then send it back to me, we have lost half of it before we start."

So, that when you have a massive Federal bureaucracy to contend with and support, a good portion of your premium money is going into needless administration. I think we want to look at that very carefully. We have seen it already in the Social Security Administration.

Mr. COTTER. Yes, I agree with you, but you know I have thrown this same question at many witnesses and honestly no one has been able to refute it.

If this is the situation, I mean they may have a believer in me.

Dr. PALMER. I don't think there is any question but that there is a pool of money that is put into health insurance each year.

Mr. COTTER. Yes, it can be estimated what is paid for medical and health costs. There is no question about it.

Dr. PALMER. But this is not being paid through taxes. This is being paid by individuals.

Mr. COTTER. Exactly.

Dr. PALMER. Private initiative into private insurance companies.

Mr. COTTER. Exactly. And the promise is, as set forth by many of these witnesses, that it would be merely a redistribution of existing health costs, but the total dollar amount is the same.

Dr. PARROTT. Well, you have had some pretty good samples of when you change the situation that it doesn't always come out the way the estimations were made. I think if you want to go back to the prime example of that, was the estimates made on medicine originally at $1.2 billion per year. That was what it was sold on.

Our testimony at that time in 1963–65 to this committee, the whole committee, was that it would cost a lot more than that. We didn't know what it would be and that has proven to be right.

Mr. COTTER. We can't very well go on assumptions. When you get an attractive program like this presented and said it is going to take care of everyone, increase benefits which are not being enjoyed now by people today and at no more additional cost, really, you know it is kind of beguiling.

Dr. PARROTT. Well, I don't think it is that big a flipflop if you look at it. Because the 80 or 90 percent of the people that are already insured will still be insured with either money matched by employers and that money stays there and stays with the insurance policy in the private sector. The thing different about it is that it amounts to a different use of the money that goes to the poor, near-poor, the unemployed, self-employed and unemployed.

Mr. COTTER. Exactly.

Dr. PARROTT. That is where the tax credit comes in. Most of that is new money. I would defer to Mr. Peterson because he knows the technology of that.

Mr. PETERSON. Mr. Cotter, in response to your question, the program that you are referring to, of course, does create new taxes in substantial amounts, figures have been mentioned in terms of $50 billion to raise taxes in the social security system which then have to be matched by taxes in the general revenues in a like sum.

So that we have a very large amount of money, some $100 billion, we use that figure generally, that would have to be raised through taxes. The impact this would have upon the economy can I am sure be best assessed by this committee.

Mr. COTTER. By the same token, you are relieving other people of that cost which must be made up by others.

Mr. PETERSON. Pardon me?

Mr. COTTER. You are relieving some people of that cost, however.

Mr. PETERSON. The question is whether that is the best place to to place that new burden of financing.

Now, as Dr. Parrott has indicated, the AMA's bill would not disturb the present system of financing and would retain the financing on the employers and the employee where the major coverage exists today; and the role of the Federal Government with its participation would be aimed primarily at assisting the poor who need the assistance. The additional Federal role would taper off through the tax credit mechanisms to assist those in the higher incomes to a lesser degree.

In our opinion, this would be the better road to follow with respect to financing. But there is more to the question involved than just financing. That is, the total program that is contemplated under H.R. 21 is involved, and this relates to what we have termed here the restructuring of the system because of the way the money would then flow from the Federal Government down into the various areas with the budgeted allocations both regionwise and servicewide.

This would create severe restraints upon the delivery of care.

Mr. COTTER. Thank you, my times is expired.

Mr. ROSTENKOWSKI. Mr. Martin will inquire.

Mr. MARTIN. Thank you very much.

Dr. Parrott, Mr. Peterson, Dr. Palmer, I would like to explore a little bit further the concept of phasing in the various options that are before us. I know that has two different meanings.

One that has been discussed in the past is that we try to design and write and adopt the whole package now by phasing in the implementation with a schedule of stages through which it would begin to take effect.

But another meaning would be, and one which I find more attractive, would be that we write it in an assimilatable package. That is, in concepts or modules that the Congress and this committee could deal with one stage at a time so we could keep track of where we are going.

If we were to take that route, which I gather you have some reservations about, it would seem to me that the first step would be some element of the catastrophic coverage and take some time to see how that works.

For example, we could take in your program and your bill, H.R. 6222, extract the sections dealing with catastrophic coverage alone, mandating that there be such coverage in all private insurance contracts, both the group contracts and in your suggestion of a pool to cover everyone else, the self-employed perhaps the uninsurables, perhaps people who are retired but not yet 65 and who make up that small percentage that don't have insurance coverage programs purchasable.

In other words, mandate such coverage for catastrophic health costs which pick up that extra person that doesn't now have catastrophic insurance coverage allowing, as you suggest, for the Federal Government to pick up the premiums for the past which avoid the distinction of setting a rigid threshold of $2,000 or $5,000 or any such figure which is not catastrophic at all for the very rich, but is way beyond catastrophic for lower income working people.

Utilizing, as you suggest the tax credit for the direct billing option as a way for the lower income people to work into this system, and by doing so you could reduce the first stage cost from the $45 billion a year which you estimate to roughly one-tenth of that, somewhere around $4 to $6 billion.

Mr. PETERSON. That would be $4.5 billion if you want to average the figure out, $4.5 billion rather than $45 billion.

Dr. PALMER. The $45 billion represents the insurance package. It is not Federal money. It is the insurance premium. It is an estimate as to what the premium package would cost.

Now, the Federal dollars would vary from an average of $3.5 billion to $4.5 billion, something like that.

Mr. MARTIN. But to give you an opportunity to see how this part of the program works, you might find that it might absorb quite a bit of the medicaid program since the poor would start out with a catastrophic medical cost right at the beginning.

I would invite your reactions to that because it would seem to me that that would be a more sensible approach than trying to design the whole——

Dr. PARROTT. You are suggesting that you leave the basic package, as I take it, or are you talking about freestanding catastrophic without the basic package?

Mr. MARTIN. I am talking about a freestanding catastrophic element, as you wrote it in your program.

Dr. PARROTT. Ours is not freestanding.

Mr. MARTIN. But it could if it were extracted.

Dr. PARROTT. It's been against our policy to go for freestanding catastrophic, simply because of the reasons that we indicated in the testimony, that the floor can be lowered to include the whole situation and the first priority is the basic package.

We certainly wouldn't want to lose that, and it is really necessary to build that foundation under catastrophic where you have a free floating situation, and the floor can be lowered to include everything.

Mr. MARTIN. But that is the criticism with programs whereby the Federal Government pays the catastrophic cost.

What I am talking about is your program where it would be mandated catastrophic coverage in the private insurance program.

Dr. PARROTT. Well, you see, if it is mandated on top of the private insurance plan, then the basic package is there: We would have no objection to that.

Mr. PETERSON. Mr. Martin, I think you will find, and certainly we would want to examine your comments here, but I think you would find that, as I understand what you have indicated, you would still retain the basic support for the poor with respect to a full program. And if that were the case, you would find that the imposition of the catastrophic coverage on top of that for everyone would—and if you would include the minimal Federal support for those as their income increases—that you would find that you would come to the full plan of the AMA with very little additional Federal support.

So you would then be able to assure, in addition to the catastrophic coverage, the provisions for the basic plan as well. And it is the basic care, which the association is concerned with as being necessary for the general population.

Dr. PALMER. Mr. Martin, I think if I were to think of modulizing the program and I grant you that catastrophic has a great deal of appeal, but on the other hand, Mr. Martin, I think there is a great need in the area of title 19 medicaid. There is no uniformity of the programs in the 50 States, and I think that this would be an area that I would want to focus my modulizing on.

Mr. MARTIN. On rewriting medicaid, rather than dealing with these other problems.

Dr. PALMER. Yes.

Mr. MARTIN. Let me ask you about another thing that surprised me, another feature in your bill. That is, you provided no deductible feature. You would provide that there would be no deductible feature in the insurance program.

It would seem to me that that would be basically inflationary to forbid a deductible feature. We have had a number of panelists from this country and from other countries, physicians that are practicing here and abroad, who generally agreed that the deductible device is essential to persuade physicians that frivolous medical appointments are not necessary.

Dr. PARROTT. Most of those have no company insurance. We didn't take coinsurance out this time. There was a deductible in the old bill in the last Congress. We took that out, but the coinsurance on people who fall into the middle categories and higher categories go from dollar one.

There is a 20 percent coinsurance. There is no coinsurance on the poor here. The coinsurance in effect, is a form of deductible.

Mr. MARTIN. Mr. Chairman, I have no further questions.

Mr. ROSTENKOWSKI. Mrs. Keys will inquire.

Mrs. KEYS. Thank you, Mr. Chairman.

I would like to ask your expert opinion about some of the very deploring weaknesses in our system that I don't see any remedy to or any way of correcting without the institution of a major comprehensive program.

We do know that of those covered by health insurance now, probably half are not covered unless they are hospitalized.

We have the fact this past year, I believe, the statistics showed that one-third of babies delivered in public hospitals, were delivered from mothers who had had no prenatal health care.

There are many other facts like these. When you go into the area of preventative care we find that our present system doesn't lend itself to encourage that at all.

Do you see any remedy for this, easy remedy?

Dr. PARROTT. Well, Mrs. Keys, the business of access for—take the maternity thing that you have mentioned.

Often this is not a countrywide thing. This is spotty. The infant mortality rate has decreased in this country in spite of the fact that people have trumpeted infant mortality rates as a kind of false indicator.

We have a definite program clear across the Nation with the specialty societies and with the voluntary health agencies of doing a better job of identifying high-risk pregnancies and getting them into certain types of care.

Our bill is particularly designed for that maternal and child care as a specific item in the bill.

The first part of your question was——

Mrs. KEYS. Excuse me, sir.

Is there a waiting period under your bill?

I didn't notice.

Dr. PARROTT. No.

Mrs. KEYS. No waiting for the coverage of maternity benefits?

Dr. PARROTT. No.

Now, the first part of your question slipped my mind.

Mrs. KEYS. You felt that a lot of weaknesses were being corrected in different ways in the present system.

Yet we have so many people that don't have coverage at all unless they are hospitalized.

Dr. PARROTT. Oh, yes.

Often that has been our way of thinking, a defect in the way the insurance policies were originally written. They are being rewritten now to allow greater ambulatory care and to do much of the diagnostic work in the doctor's office and outside the institutional setting, which we think has proved to be of lesser cost.

Now, there is a problem with this. When you open ambulatory care, we have the utilization problem in the doctor's office, overutilization, because it is just there.

We think the safeguards can be built in to cut that particular problem and that the diagnostic work can be done cheaper outside the institution and thereby cut the costs.

It hasn't been totally accomplished as yet. There are still policies with inpatient necessity for payment and we have been trying to correct that.

Mrs. KEYS. I notice that you stated that you felt that some of these weaknesses were being overcome and that we were experimenting with alternative systems and alternative types of procedures.

I wonder if you would agree that medicare should be changed in order to provide remedies and reimbursments to physician extenders, nurse practitioners, et cetera?

I know there are experiments being done in that particular area.

Dr. PALMER. Mrs. Keys, I would want to know, I think, a little more about this. There are all sorts of, I suppose, extenders that would be paid under a national health insurance program, but the first thing you know you are going to have people of very questionable qualifications.

I think I would have to look at each individual before I could give an opinion on that. I would be very cautious about paying extenders.

Mrs. Keys. Let's take the problem of Mr. Duncan's clinic where a nurse practitioner is operating, and, I am sure that this includes dealing with many people who are served by medicare.

Dr. Palmer. I would presume the nearest practitioner would be in some sort of corporate structure, in which case the provider would be the corporate structure, and often they would be eligible for payment.

Mrs. Keys. One last question.

Don't you feel that we have really prepared ourselves in a great measure for a national health insurance program by the institution of our health resources development, our health planning, our manpower programs, the PSRO, utilization review, et cetera? Have we not stepped a great deal up the way in trying to ready ourselves for the delivery of health care to people?

Dr. Parrott. It depends again on the point we came to make. What kind of national health insurance scheme are you talking about?

We might agree with your statement if you are talking about the bill we are presenting. We certainly would not agree with the Kennedy-Corman approach.

Mrs. Keys. I guess I believe sincerely that in 1975 everybody has a right to expect to get quality health care they can afford or prepay in some fashion.

Dr. Parrott. I don't disagree with that.

Dr. Palmer. We have no quarrel with that statement.

Mrs. Keys. Thank you.

Mr. Rostenkowski. Mr. Corman will inquire.

Mr. Corman. I am apprehensive when they turn to California and elsewhere for their precedent, but I must say I think they have done quite well.

We are still not precisely in agreement, but I have noted some movement in your association toward the Kennedy-Corman bill. You moved from medicredit to the Nixon proposal. Heaven knows where you will be in another 10 years.

We have had some insurance representatives in here earlier in the week and I think that at least your staff might be fascinated by their testimony.

The insurance companies are a very integral part of your program.

One of them said that to get some kind of realistic control on inflation in health care that the insurance companies are going to have to be empowered in some way to regulate those companies. Unless they had that, after all they would just be the conduit program between the insured and the provider.

And as there is more insurance, there is more insurance ability to pay. As there is more ability to pay and there is a tendency for increased costs.

Would you comment on whether or not you think the insurance companies have a role in controlling doctors' fees and hospital bills?

Dr. Parrott. Well, I would say that the insurance companies have had perhaps more experience in claims and in the way claims are adjudicated than any other group of people in the country, including the Government.

Now, in the past these things have been adjudicated basically throughout State and county medical societies, committees, and so on in conjunction with companies, claims review committees.

In other words, if there is fallout or a man is off the profile, he could be brought before these types of committees. That is the discipline that has been used in the past.

In many areas it has worked very well. In some areas I don't think it has worked at all that well. Now, the main point I want to make is, in claims review and in the ability to cooperate with the profession the insurance company has a pretty good track record.

Mr. CORMAN. Does this have to do with utilization of service or fee charged?

Dr. PARROTT. Mostly with the fee charged. The over utilization has to be done under a peer review situation. There is a difference between peer reviews and claims review.

You know, one of our big problems with peer study review is that it will be relegated to a cost containment situation solely without taking into effect quality controls. And we can't accept it on that basis. Its primary purpose has to be quality control.

Mr. CORMAN. But you are not apprehensive about the insurance companies participating with you in figuring reasonable fees?

Dr. PALMER. Not as long as we can work with them.

Dr. PARROTT. Not as long as the Sherman Antitrust Act doesn't come back to haunt us.

Mr. CORMAN. I wondered about that point, also.

As you say, if I go to the doctor and he charges me $10, and I reach in my pocket and hand it to him, I got a $4 tax saving, I guess. And he has a $5 tax obligation.

[General laughter.]

Mr. CORMAN. Usually, unless he has a good lawyer.

But when I send him that $10 through the Government, as you say there is some shrinkage in the laundry. Is not there some of that, too, if I send it through one of 600 private insurance companies, too?

Dr. PALMER. Yes, but Mr. Corman, the shrinkage is usually less. If I recall, the Senate ordered a study on this subject in 1973 and found that the administration, in claims handling, was considerably higher when done by the Government than when done by private industry.

Mr. CORMAN. I am sure you would be interested in Social Security's response to that, and I am not sure who is right.

Dr. PALMER. I know they did respond.

Mr. CORMAN. But we are talking about administration now. They have underwriting and selling costs. Selling costs are a particular factor if I am one of those unfortunate people who does not belong to a large group of insured employees, but rather, have to buy my own insurance. There is a good bit of shrinkage in the underwriting and selling costs. Marketing costs from 20 to 40 percent, most of the insurance companies tell us. So, I really wonder of all the dollars that flow into the hands of insurance companies now, what percentage really wind up in the hands of people taking care of our ills?

Of all the dollars that flow into the medicare and medicaid system from taxpayers, how much of it goes into the hands of those who are providing the care?

I suspect that when you look at those figures the Government does at least as well as insurance companies.

Dr. Parrott. We are talking about administrative overhead now.

Yes; I presume the Government has administrative overhead the same as insurance companies do. I am not enough of an expert to know the details where it has a better cost-benefit ratio in one place or another, but certainly there are areas where private industry has had a better cost-benefit ratio than Federal Government.

But there is a lot of complexity and variables when you talk about Federal Government budgets because they don't seem to work with the same bookkeeping system as does the private sector. And I presume that they have some legal advantages which the private sector does not have.

Mr. Corman. That is the big thing they do not have. In fairness to the private insurance companies the Government does not have any selling expenses. The insurance companies do, and will always have, even to the degree of compulsion that you want to have imposed on the American people throughout the entire plan.

There will still be some people who will have to be sold the policies. So there will be a marketing expense that there is not under a program such as Kennedy-Corman program.

I think that all of the things that happen in the next 2, 3, or 4 years this is the most worthy of careful consideration. If I wind up believing the GAO report and disbelieving the Social Security response, then I would favor contracting out administration of the Kennedy-Corman program to private insurance companies.

But to go the next step is not prudent and say that we ought to just leave it to the private insurance companies to work with the doctors to get a handle on health costs. The doctors have been working closely with the insurance companies trying to get a handle on the costs of malpractice insurance and their record there does not present a good prospect.

A good friend of mine is a gnyecologist in my district, and he has never had a claim filed against him. He is a good example. He is paying the insurance companies $36 thousand a year for malpractice insurance.

Are insurance companies really able to play a constructive role in all these things?

Dr. Parrott. They are not able to explain it and we have not seen the hard data on why this occurs. We have talked to them on three or four different occasions at the highest level.

The problem, they advise, is that their casualty business is so tightly interlocked with the medical liability business that they can not get pure data out.

Now, you know that we are trying to solve this situation in some ways, in many ways, as a matter of fact.

It looks to me now that, in order to save money or get the premiums down, the doctors are going to have to insure themselves for two reasons:

First off, it is the only way to go. And the other is that is the only way to get hard data on what the situation really is.

Now without reforms, often we can go as broke as insurance companies.

The American Medical Association will reinsure those companies if the demand is made.

Again, as I started out to say when I answered a previous question, the medical liability problem is the greatest crisis we face at the present time, and it has a definite effect upon the cost of medical care. And it has an effect upon the cost of health care also because the institutions are in the same kind of bind and just moving the doctors into institutions is not going to be the solution.

Our big crisis is to get our young people into practice, either institutional practice, or individual private practice. It is going to be a big problem to us come May. We would like to appraise both the Congress and public bodies of that problem because it is real, and it has a real effect upon what the manpower will be in the field. And, therefore, it has effect upon the quality and availability of medical care.

Mr. Corman. Whether we like it or not your profession and mine are very closely intertwined.

[Laughter.]

Mr. Rostenkowski. Are there further questions?

Mr. Martin. Mr. Chairman, I have a few.

I wonder if I could go on record for one or more questions.

Mr. Rostenkowski. Mr. Martin.

Mr. Martin. Part of the discussion of this subject, Dr. Parrott, has been with regard to perceptions of the public as to whether and how a national health insurance program should be constructed.

This was quite apart from some of the design features anticipated, the question of whether or not they are willing to pay for it. Just yesterday a witness testified that he discerned that the public was ready for national health insurance.

This was based on soundings which he had taken at the board meetings. I notice, on page 2 of your testimony here, you have a rather intriguing sentence, "We have observed a shift in attitude towards such a national program.

I would suggest that your selection of the preposition "toward" might allow some misinterpretation of what you are trying to say. And, therefore, I would ask you to interpretate that for me. What kind of a shift are you observing, and how do you observe it?

Are attitudes shifting toward such a national program, or are you saying that attitudes toward such a program are shifting? If so, which way?

Mr. Peterson. We are saying the attitudes are shifting, but not in favor of the national health insurance. I can understand the ambiguity in the sentence you have pointed out.

The sentence here in the statement was intended to indicate that during the course of the debate before the Congress over the past several years with respect to national health insurance, that there has been a shifting of attitudes toward a national health insurance program in the sense that during the course of the debate there have been many problems that have been identified. And certainly some of the factors that were identified were the need to buttress and to strengthen some of the elements that would have to go into such a program.

Mrs. Keys made reference to that with respect to the development of the manpower facilities and so forth that would be essential components of any national health insurance program. But as the debate ensued before the Congress there were different problems that were identified and perceived. And there were shifts in areas and various national health insurance programs, even before the Congress.

This was what was meant.

Mr. MARTIN. Well, you are saying in general the shift is away from a comprehensive national health insurance program?

Dr. PARROTT. I think you are talking about two different groups of people. The awareness in the shift and the drive toward comprehensive national health insurance program has been basically among the legislators of the Nation, both State and national.

Just the opposite effect from what we have picked up on certain polls like the Harris poll aid a poll we have run ourselves where awareness of the national health insurance problem is about 18th on a list of 20.

Dr. PALMER. Two percent of the people in the last Harris poll indicated high priority for health care.

Mr. MARTIN. But that doesn't tell us anything about the number that might have put it down as number two, three, or four as a relatively high priority.

Dr. PALMER. Eighty-two percent were interested in the economy, though.

Mr. MARTIN. Sure.

Dr. PALMER. Two percent in health care.

Mr. MARTIN. Of the 2 percent how many felt it was second or third in priority? All I can say is that it doesn't answer that question.

Mr. PETERSON. Some of the other problems we referred to are problems that we have seen in the national health insurance programs in other countries, and I think we have seen, for instance in England, their recent action in establishing a commission to examine their program now.

These are problems that have come to light now, and I think it is just a cautionary note that these problems have to be examined carefully for their impact on our delivery system.

In our own Government programs, about which I know this committee has held very beneficial hearings with respect to some of the administration problems, we have seen some of the problems that have surfaced in those programs.

Mr. MARTIN. Just regarding the shift in attitude toward which is important because it gives us an insight as to what the public perceives to be the problem, would it be fair to say that the public attitude shift has been away from a comprehensive health insurance program, but toward what the public may be perceiving increasingly to be a need for catastrophic coverage or any such component of the problem?

Dr. PALMER. I think that that is perhaps a fair statement, Mr. Martin. I think that as I see the American public, the public I talk to, they don't want more taxes, and yet, want this security of catastrophic health insurance.

Mr. MARTIN. Thank you, gentlemen.

Mr. ROSTENKOWSKI. Thank you, gentlemen.

We appreciate your testimony.

Mr. Clayman, please.

Welcome to the committee, Mr. Clayman. If you would identify your organization and then proceed with your testimony.

STATEMENT OF JACOB CLAYMAN, SECRETARY-TREASURER, INDUSTRIAL UNION DEPARTMENT, AFL–CIO, ACCOMPANIED BY HOWARD HAGUE, JR., LEGISLATIVE STAFF MEMBER

Mr. CLAYMAN. Thank you. I have Howard Hague, Jr., with me, who is part of our legislative staff in the industrial union department. If I may, I would rather not read a good part of my statement and hope that the statement will be placed in the record notwithstanding.

Mr. ROSTENKOWSKI. Without objection your entire statement will be placed in the record, Mr. Clayman.

Mr. CLAYMAN. As I was sitting back in the room a few random thoughts came to mind and I hope you will indulge me if I simply relate them to you.

Over the years I have sat in other committee hearings like this on the same issue that we are here considering, and varying degrees of enthusiasm and opposition were presented. I remember that, what, 35 years plus, the first Murray bill and then after that the Murray-Dingell bill, which goes back to the Roosevelt administration, and for 35 years now we have been debating this issue.

I don't know what kind of stories these old walls could tell us if they could speak. The reason I am not reading my testimony is that it is old stuff. You have heard it over and over and over again. This doesn't distract or add to its validity, but that is the fact.

The one hopeful sign to me ls that I sense, listening today, a somewhat quiet erosion of the opposition. Once upon a time, even in my day, the charge national health care legislation would be "socialism" and all the rest, every horrendous allegation would be made. But now it is much quieter and in my view at least much more rational.

If I may point out an individual experience, I was in Ohio with the labor movement years ago and as recently as 1959 we had a titanic battle in this State, yes or no, shall HMO's be permitted by statute?

That was only 1959. And, finally, we won after an enormous battle over the prostrate body of the Ohio Medical Association and, wonder of wonders, all of us now on all sides proclaim the worthiness and effectiveness and usefulness of HMO's.

So at least as time has gone on, the opposition has somewhat eroded and yet the basic opposition to a bill like H.R. 21 still is relatively rampant. I said I didn't want to read the testimony, very much of the testimony, that appears in my statement, but I do want to read a resolution which our Industrial Union Department in its convention in Pittsburgh in September of this year approved unanimously.

Incidentally, if we are told there is no serious interest in the general public, at least I can tell you that in the labor movement this is a live issue. No convention, no conference, no gathering of trade unionists anywhere in this country will leave the meeting without some consideration or discussion of this issue, and I believe that the polls may simply indicate the surface reactions that they probe, but fail to get at the reality.

Indeed, in the face of joblessness and inflation, high interest rates, what other issues are relevant in the minds of the overall public?

I am now reading from the resolution of the industrial union department.

In arguing that current inflation precludes enactment of a national health care program, the administration is turning its facts upside down. It is precisely because the cost of living is going up that we must have national health insurance now. Rising costs only underscore an alarming fact: That while the United States spends more for health care than other industrialized nations, it is getting a good deal less for its money.

The cost of health care through private sources has increased from $12 billion in 1950 to about $116 billion in 1974. We now spend more of our gross national product for health than any of the European countries; indeed, any country that has a national health insurance program. They spend about 5 or 6 percent of their GNP. We spend about 8 percent of ours.

And for each individual the cost of medical care has risen from $78 in 1950 to $328 in 1974. In 1955 health benefits cost the average worker a nickel of his hourly wage; now it costs him 56 cents.

Let me add, this is not in the resolution, but the Federal Government workers will be getting a 5 percent increase and I am told that of that 5 percent increase anywhere from 4 to 5 percent of the entire increase will go to pay for the additional health program. All of it will go not to buy groceries and pay the rent, but will go into the higher cost of a health program for Federal workers.

The quality of benefits has not improved. Indeed, we lag increasingly behind the other industrialized nations of the West, all of whom have national health systems. You heard these statistics ad nauseum, I know. The last time—they may have changed since I looked last—but on those important indications of the worthiness of a health system in a given country, longevity and infant mortality, do we stand now at 12th or thereabouts? Do we stand 17th or 18th? I have seen it even at 22d.

This has to convey some kind of a message to all of us that using the only standards we have which are reasonably scientific, namely, longevity and infant mortality, we fail to meet the quality of medical care achieved by some other countries.

Nowhere is the discrepancy greater than in the area of hospital care. In the past 30 years hospital costs have gone up 1300 percent, and I add to the resolution the word "horrendous."

The reasons behind this increase are plain enough. Changes in technology, increased demands for hospital care, rising costs of labor and supplies have all fed the staggering rise. Some reforms could help alleviate the hospital situation. Since 25 percent of our present hospital capacity goes unused, we need to regulate new construction. And the introduction of new and novel equipment should be regulated geographically.

All of us are aware of this observation that our resolution makes, but in the main we have yet not done anything about it. My guess is, and I don't speak with great authority at this point, that the medical people, the hospital people know this, are aware of this, concerned about this, and yet so helter-skelter is the health operation, the health system, that it goes on without serious attention.

Therefore, new equipment costs are reflected in a patient's bill. Therefore, expenses could be reduced if several hospitals, in relatively close proximity to each other, shared little-used equipment.

Well, I am moving on because I see that time is chasing, and I don't want to unduly burden either the patience of the committee and I want to be reasonably fair with those who are going to follow me, and so I am coming to the conclusion, Mr. Chairman.

Now therefore be it resolved: The industrial union department wholeheartedly endorses the Health Security Act (H.R. 21, S. 3) and urges its prompt passage by Congress as offering the best hope of achieving for all Americans the right to full and effective health care, regardless of income or station.

And now I come to my peroration. I want to read the conclusion of my statement. It may sound corny, but I believe it.

Let me anticipate history. We are convinced that when the history of the 20th century is written, those who follow us will wonder why the United States waited so long to reform its health care system. This is 35 years since the bill was introduced, the first bill.

Historians will note that most of the industrial nations of the world had already by 1975 adopted successfully comprehensive health care national systems and that they have worked well for their people. The people that I know in the labor movement who have gone visiting abroad have all come back uniformly with the story that the peoples of those countries were satisfied with their national health programs.

Sure, they have the usual kinds of gripes, but no one, no one politically, whatever party in England, for example, would have the temerity—Conservative, Liberal, Labor—would have the temerity to suggest that their program return to the kind of fee-for-service operation that they had once upon a time and we have now.

They will observe, these historians, that although we spend more money than any other nation in the world, reckoned on any basis, per capita, percentage of gross national product, et cetera, that our results in terms of human health and life are indifferent—worse than a dozen or more countries, all of whom have national health programs.

They will report gross inefficiencies in our health care delivery system in which some few poor and the rich could get adequate broad-gaged medical attention, but that the great mass of humans in between these two extremes simply could not afford necessary health care.

They will look at situations such as I had reported to me the other day—that of a young father and mother who received a hospital bill of more than $1,200 for a 6-day stay at a hospital here in the Washington area, in the suburbs, involving a normal birth of a baby. This was separate and beyond the physician's charge. And perhaps those historians will ask how could young people in 1975 contemplate bringing children into the world at such unmanageable costs?

All of this we know. The record is replete. It is piled and stacked so high that you would have to be utterly unobserving to miss it. Yet so far we have done nothing seriously about it.

I think I must retract that statement somewhat. We have a medicare bill, we have an HMO bill, we have some manpower legislation, but in the main we have not aimed at this issue that I have described to you. How does a normal person, normal family, young man, working, afford current health care costs.

He probably makes about $8,000, $9,000, $10,000 a year gross. How does he take care of $1,200 bill for the simple business of a birth? That doesn't include, as I have indicated, the doctor's bill.

Well, here we are. If you believe, with me—this is an assumption that all of us won't make, I suspect—that a future Congress will pass such legislation and I earnestly believe that it will. It may not be this year, it may not even be next year, but it will come to pass. It will be in our time because the general public and the American consumers will demand it, because it is right and it is necessary. So I ask the question, why wait? Why not do it now?

Mr. Chairman, members of the committee, you have been patient listening to me exploring my own prejudices. They happen to be the prejudices in my judgment of most of the people of America. I hope that at long last we will have a bill like H.R. 21 as the law of the land.

Thank you.

[The prepared statement follows:]

Statement of Jacob Clayman, Secretary-Treasurer, Industrial Union Department, AFL-CIO

It is a truism to observe that our health care industry is in a crisis. While it is the third largest industry in the United States and employs 4.4 million individuals, it is ironic that adequate health care is beyond the means of millions of Americans.

The cost of health care to consumers staggers the imagination when viewed in the framework of the past two and a half decades. In 1950 the national spending was $12 billion or 4.6 percent of the Gross National Product; in 1960 spending to $25. 9 blllion or 5. 2 percent of the Gross National Product, in 1970 spending rose to $68.1 billion and in 1974 our national spending reached $116 billion. No other nation in the world matches this mind-boggling cost.

Though health care costs in the United States are beyond belief and comprehension, we might not be so deeply critical and distressed if we did as effective or better job of protecting health and life than the many countries which spend much less per capita on health care. Of those commonly recognized standards which really test the value of national health systems, longevity and infant mortality, we perform worse than many of the nations whose health care budgets are much more meager than ours. Why? because those countries which out perform us in caring for the health of their nationals *all* have some form of national health insurance.

We start out with a basic assumption, that health care should be delivered as a matter of right, not as a matter of income or social status. Income and means tests must be abandoned; co-insurance and co-payment are incompatible with the concept of quality health care as the human right of each and every American. In our judgment, H.R. 21 is the only bill before this Committee which achieves this laudable standard.

The administration makes no pretense of providing health care as a right. Indeed, it would require every person, no matter how low his or her income or how desperate their need, to pay part of their medical costs. Thus, almost automatically, the Administration's proposal effectively closes the health door on millions of our population.

EXTENT OF COVERAGE

National health security (H.R. 21) would provide universal coverage; this means all residents of the United States regardless of age, income or geographic location.

The gaps in coverage in the Administration's program are great and this is because the health bills other than H.R. 21 divide the population into separate groups such as the elderly, the poor, the unemployed and employed, etc., and because it is a voluntary program, many will opt out—taking a chance that illness will not come their way.

Employees not covered by social security and the self-employed would not be included in the coverage of several of the other proposals unless they elect to participate in an individual program. Further, some low income and aged person may also elect not to participate under various other bills offered because the means test would strip them of their dignity.

The plain fact is that unless the national health insurance plan contemplated by H.R. 21 is enacted, a significant portion of Americans will not receive necessary health care.

BENEFITS

It is our belief that a single standard of truly comprehensive benefits is essential to national health insurance.

Comprehensive benefits mean the complete range of care—from preventive to curative care. It has been shown repeatedly that many individuals do not seek proper preventive care of early diagnosis and treatment if there is a financial obstacle to obtain that care. Early diagnosis and proper treatment are more effective and less costly than acute care when the illness becomes more advanced.

For example: HMO's which provide pre-paid comprehensive health care have proven their effectiveness, both financially and in health terms—of keeping people well rather than treating them only when they become ill. Therefore, a workable national health insurance program must emphasize preventive care and early diagnosis and treatment. Of all the bills offered only national health security would do this.

High-deductible and co-insurance requirements are precisely the type of financial obstacles that deter individuals from seeking preventive care and early diagnosis and treatment.

METHOD OF FINANCING

The Industrial Union Department has long believed that national health insurance should be financed through the proven social insurance method. The health security program we support is financed by social security-type taxes and general revenues. This type of financing is fair and far more equitable than insurance premiums which are determined in the absence of public accountability.

In terms of financing, the Administration's proposal is totally inadequate. The Secretary of the Department of Health, Education and Welfare argument that the Administration's plan would not require a tax increase is completely erroneous. The Administration's bill would compel employers to pay health insurance premiums to private insurers. It is a foolish assumption to think that when the government requires payment of money for health insurance to any organization it is not a tax. When the Federal Government levies taxes it is for specific purposes and the Government controls the way it is spent. Under the Administration's plan, the Government would enforce the payment of taxes and then, in effect, turn the money over to private, and in many cases profit-making, insurance carriers with only the most minimal regulation.

Therefore, we find health security to be by far the more superior of the proposals in its financing.

QUALITY AND COST CONTROL

H.R. 21 has, without question, the strongest quality and cost control provisions of all the proposals before this Committee. Quality controls can not only measurably elevate the quality of health care, but can also aim a blow at the extraordinary high cost of health services.

For example, the elimination of unnecessary surgery and hospitalization, which is enormously high in America, can both improve the quality of health care received by Americans and reduce cost.

There are several areas which cost controls are an absolute necessity—physician fee schedules, surgery, and hospital budgeting. H.R. 21 and the Administration plan would establish fee schedules. However, H.R. 21 would require all physicians to accept the fee schedule as full payment for services rendered. The Administration plan would require physicians to accept the fee schedule as full payment only from those persons covered by the public plan. Therefore, those persons covered by the employer plan would become preferred patients because they could charge these individuals more even though the patient, not the plan, would pay the cost.

CONSUMER REPRESENTATION

Of all the bills offered, only health security would provide a significant role for consumers at all levels in the development and administration of the Nation's health program. For too long these decisions have been made by doctors, hospital administrators, and insurance company executives. It is time the people had an opportunity to participate in decisions affecting their own needs.

CONCLUSION

Let me anticipate history. We are convinced that when the history of the 20th century is written those who follow us will wonder why the United States waited so long to reform its health care system?

Historians will note that most of the industrial nations of the world had already by 1975 adopted successfully comprehensive health care national systems and that they have worked well for their peoples.

They will observe that although we spend more money than any other nation in the world, reckoned on any basis, per capita, percentage of Gross National Product, etc., that our results in terms of human health and life are indifferent—worse than a dozen or more countries, all of which have a national health program.

They will report gross inefficiences in our health care delivery system in which some few poor and the rich could get adequate broad-gauged medical attention but the great mass of humans in between these two extremes simply could not afford necessary medical care.

They will, not overlook the uneven spread of expert health personnel and facilities in the country, an over abundance of physicians in some cities and a great scarcity of doctors in other areas.

They will look at situations such as I had reported to me the other day; that of a young father and mother who received a hospital bill of more than $1,200 for a six-day stay at a hospital involving a normal birth of a baby. This was separate and beyond the physician's charge. And perhaps those historians will ask how could young people in 1975 contemplate bringing children into the world at such unmanageable costs.

And, too, they may very well ask where were the political leaders of that day; why did they not note the experience of the world on health care and reformed an unconscionably expensive, wasteful, inefficient and ineffective system which served us so poorly?

But one day we will pass a comprehensive national health security bill in Congress because it's time has been long overdue. It maybe in this Congress or the next Congress but it surely will arrive because the people will need it and want it. And when that event comes to pass we will ask ourselves, along with the historians, why did we wait so long?

If you believe with me that a future Congress will pass such legislation, why wait, why not do it now? The speedier Congress acts, the more lives saved, the more fellow human's health will be restored.

We earnestly urge your support of H.R. 21. Why not do it now?

The attached resolution was approved by the Industrial Union Department Convention in Pittsburgh on September 11, 1975.

Resolution No. 25—National Health Insurance

In arguing that current inflation precludes enactment of a national health care program, the Administration is turning its facts upside down. It is precisely *because* the cost of living is going up that we must have national health insurance *now*. Rising costs only underscore an alarming fact: that while the United States spends more for health care than other industrialized nations, it is getting a good deal less for its money. The cost of health care through private sources has increased from $12 billion in 1950 to about $116 billion in 1974. We now spend more of our Gross National Product for health than any of the European countries. They spend about 5 or 6 percent of their GNP. We spend about 8 percent of ours. And for each individual, the cost of medical care has risen from $78 in 1950 to $328 in 1974. In 1955 health benefits cost the average worker a nickel of his hourly wage; now it costs him 56 cents. And the quality of benefits has not improved. Indeed we lag increasingly behind the other industrialized nations of the West, all of whom have national health systems.

Nowhere is the discrepancy greater than in the area of hospital care. In the past 30 years, hospital costs have gone up 1,300 percent. The reasons behind this increase are plain enough. Changes in technology, increased demands for hospital care, rising costs of labor and supplies, have all fed the staggering rise. Some reforms could help alleviate the hospital situation: since 25 percent of our present hospital capacity goes unused, we need to regulate new construction. And the introduction of new and novel equipment should be regulated geographically. New equipment costs are reflected in a patient's bill. Therefore, expenses could be reduced if several hospitals, in relatively close proximity to each other, shared little-used equipment.

Such changes, however, do not come to grips with the general problem. There will be no substantial improvement in the quality of medical care and no real move toward keeping health care costs from becoming prohibitively high, unless we adopt a national health insurance system.

Since we already spend more than $100 billion for health care, we are not talking about new expenditures. We are talking, rather, about shifting from our present patchwork health care to a national system that will make health care accessible and affordable to every American who needs it.

The National Health Security Act (H.R. 21, S. 3), embodies the kind of health care system that becomes more essential with each day the cost of living goes up. While inflation almost inexorably moves upward, the rate at which the cost of health care rises is 50 or 60 percent faster. And predictions that a national system will fuel inflation are largely unfounded. Even the Department of HEW, no friend of the Health Security Act, admits the pending legislation would add only 10 percent to the cost of health care and that estimate takes no account of the savings that would be realized by the changes the Act contemplates in the health benefits delivery system.

The National Health Security Act would establish a program in which:

Every resident of the United States would be eligible.

All health services, including catastrophe coverage, would be available.

Administration would rest with a Health Security Board, within the Department of HEW, which would establish policy, standards and regulations.

A Quality Control Commission would develop cost control features including national standards for providers of health care.

Effective participation of consumers in the development of policy would be assured.

More efficient organization of existing health manpower would be encouraged and funds provided for special training of health professionals and allied personnel.

Operating expenses would come out of a Health Security Trust fund financed by a special tax on employers, employees and the self-employed and matched by a like amount out of federal revenues.

Physicians, dentists, hospitals, nursing homes and other health care providers would be paid in full directly from the health security trust fund and the patient would not be charged more.

A Resources Development Fund would be established to support innovative health programs, particularly in manpower, education, training and group practice.

Financial, professional and other incentives would be built in to encourage organized arrangements for patient care such as health maintenance organizations and other prepaid group practice plans or professional foundations.

Preventive care, early diagnosis of illness and medical rehabilitation would be encouraged; now therefore, be it

Resolved, That the Industrial Union Department wholeheartedly endorses the Health Security Act (H.R. 21, S. 3) and urges its prompt passage by Congress as offering the best hope of achieving for all Americans the right to full and effective health care, regardless of income or station.

Mr. Rostenkowski. Thank you, Mr. Clayman. I can assure you that we hope, too, that this is your last appearance with respect to testifying on this subject, only because I hope we will pass National Health Insurance.

Mr. Clayman. We shall build monuments to all of you.

Mr. Rostenkowski. Mr. Corman will inquire.

Mr. Corman. Thank you, Mr. Chairman.

I want to express my sincere appreciation for your support of H.R. 21. As I listened to the doctors just before you and thought of their malpractice insurance problems, it seems they are in the position of the American people, in respect to their health care. The doctors do not want to assume individual responsibility for their malpractices, and the individual American does not want to assume individual responsibility for his health cost because they may be too big to handle.

So the insurance companies that the doctors are relying on raise their premiums, but the premiums got too big. The doctors think they were getting too little for their money and now they want to become self-insurers.

That is exactly what the American people would do under H.R. 21. They would become self-insurers through a health security program. I wish the doctors could see that analogy because they have had such miserable luck with the insurance companies. They should not entrust this area of national health insurance to the insurance companies.

Mr. CLAYMAN. If I could comment quickly apropos your observation, as you folks say, I associate myself with those remarks.

Your bill solves, Congressman Corman, part of the problem—not all of it, but part of it—by eliminating from the legal calculations of damages the question of medical costs and hospital costs, because the bill would provide that cost to all in the country. At least the doctor would be relieved to the extent of the cost of medical care to take care of the damage which presumably occurred by his negligence.

Mr. ROSTENKOWSKI. Mr. Duncan will inquire.

Mr. DUNCAN. I have no questions, Mr. Chairman. Thank you.

Mr. ROSTENKOWSKI. Mr. Cotter?

Mr. COTTER. No questions.

Mr. ROSTENKOWSKI. Mrs. Keys?

Mrs. KEYS. I have no questions other than to say it has been a delight to hear someone testify before this committee who obviously has such concern and care for the health of the people of this country.

I hope all of your wishes come true, because they are mine, too.

Mr. CLAYMAN. That is great news to me. Thank you.

Mr. ROSTENKOWSKI. Mr. Crane will inquire.

Mr. CRANE. Thank you, Mr. Chairman.

Mr. Clayman, I don't know the specific case you are referring to here of a normal delivery in the Washington, D.C. area with a $1,200 hospital bill. I know my wife delivered 2 years ago at Columbia Hospital, normal delivery, and it wasn't a fraction of that.

Mr. CLAYMAN. Of that cost?

Mr. CRANE. Right. I think you have to be a little guarded about generalizing from specifics. I would appreciate if you could provide me some details of that.

Mr. CLAYMAN. I shall be happy to do it. I would have to ask the person who revealed it to me whether they want their name indicated to you. I would be happy to do it in confidence in that respect.

Mr. CRANE. Well, are you suggesting that that is normal or an aberration?

Mr. CLAYMAN. Normal?

Well, let me tell you I was told that the cost for the mother, the hospital cost, was $123 a day, and it is semiprivate, two to a room. And I was told—which struck me as odd, babies have been in my long past, so I didn't remember—$85 a day for the little baby in the nursery.

Well, there you have it, you see.

Mr. CRANE. My only question is are you suggesting that this is a normal cost for an uncomplicated delivery in Washington, D.C.?

Mr. CLAYMAN. I suspect so——

Mr. CRANE. You don't really know?

Mr. CLAYMAN. Because this was a case of a normal delivery, 6 days.

Mr. CRANE. I know we have had rampant inflation over the past 2 years, but I find it hard to believe it has been that up increased.

Mr. Clayman. Let me doublecheck on those figures, if I may, Mr. Crane, and at least tell you what they are in detail. I don't know whether the person involved will want to have her name told to you, but I will give you the details on this.

Mr. Crane. Was that family insured, do you know?

Mr. Clayman. That family would be partially insured, because the husband works and they have some kind of Blue Cross-Blue Shield.

Mr. Crane. That provided quite a buffer for us, I know.

Let me get to a couple of statements in your testimony. You refer to the commonly recognized standards which really test the value of national health systems, longevity and infant mortality.

You indicate that we perform worse than many of the nations whose health care budgets are much more meager than our own. Then you answer your own question. You say, "Why? Because these countries which outperform us in caring for the health of their nationals all have some form of national health insurance."

I submit to you that that is a non sequitur, but using these criteria of evaluating a health care system you don't seem to take into consideration some of the cultural differences between nations that account for longevity. For example, the astronomical number of people that we kill on highways, consumption of cigarettes per capita, consumption of alcohol per capita, what-have-you, and I don't think to attempt to make the correlation between longevity here and elsewhere, as you have done, based upon the assumption that a comprehensive health system is the explanation, is accurate.

But looking at infant mortality rates, where did you get your figures—dealing with infant mortality rates and how they stacked up against other industrial nations?

Mr. Clayman. They are the commonly accepted statistics that are available to all of us, and I will be prepared to submit to you noting chapter and verse of the statistics, sources, and all.

Mr. Crane. World Health Organization, infant mortality statistics, would that be your source?

Mr. Clayman. That would be one source.

Mr. Crane. Did you read those?

Mr. Clayman. No, I did not.

Mr. Crane. But if you look at that, there is attached to that a caveat pointing out you cannot make infant mortality rate comparisons amongst nations. For one thing they use different criteria for defining infant mortality. In some cases it is the weight of the infant at birth, in other cases they have up to 90 days to report anything, 90 days and under is not an infant mortality. In other countries there is up to a 5-year period in which parents have the duty of reporting an infant mortality.

Midwives deliver babies; and the abortion on demand Japan used long before we contemplated those policies here. If you compare the rates with the United States with a comparable region such as the Common Market countries, all of whom have a comprehensive health system, and our rates are lower than theirs, Mr. Chairman.

Mr. Clayman. Well, you are suggesting something that I have never heard presented or read and I would like to——

Mr. Crane. I would be happy to provide it for you.

Mr. Clayman. I will be happy to get them and I would like to provide you with the source of the basic statistics that I used and provide it to the entire committee. Incidentally, I have heard over the years the argument that you have suggested, namely, population structure, homogeneous people, and cigarettes and alcohol. But I am afraid you are on weak ground.

We don't do much worse than most of the world in that area.

Mr. Crane. Oh, I don't know. I think we have the highest alcohol consumption per capita of any nation in the Western World with the possible exception of France, and I heard that can't be proved because they are switching to milk and breaking the kids of the wine habit.

Mr. Clayman. I have heard your argument and I specifically asked people, medical people who are experts, and I have asked, is this argument valid? They disagree with you, the ones I have asked.

Mr. Crane. We have had a lot of testimony by medical experts here that suggests that, raised hope for improved health conditions lies not in mechanics of what we do in terms of improving technology, improved service, better doctor-patient ratios, what-have-you, but changing the habits of people in terms of more exercise, more diet, eliminating bad habits, safer driving, what-have-you.

Let me quickly, because I am going to run out of time here, get to one other question.

That is your basic assumptions that you start with; namely, that health care should be delivered as a matter of right and that there should be no income or means test.

How, first of all, do you define a "right"? Would you say that is something to which someone has a just and righteous claim?

Mr. Clayman. Well, that is one definition. I suppose you define it, the Catholic church talks about natural rights. I suspect in a sense this is about as natural a right as you can come across, at least that I can come across in my thinking.

This is the basic in a sense, the basic right to health and life, and I don't know of any right that is more preeminent in our society than that.

Mr. Crane. How about food?

Mr. Clayman. What is that?

Mr. Crane. How about food?

Mr. Clayman. Food? Well, you are going to press that point, aren't you?

I would say, too, that as a matter of right people have the right to live and food is one aspect of the right to live.

Mr. Crane. Is that a more preeminent right than a right to health?

Mr. Clayman. I would say that they are both of equal importance.

Mr. Crane. So would you recommend then a national program recognizing everybody's right to food without a means test?

Mr. Clayman. If I had—I could order this world—which I can't, you see.

Mr. Crane. You would?

Mr. Clayman. I would aim in that direction.

Mr. Crane. And housing?

Mr. Clayman. I would aim in that direction without any apprehension.

Mr. Crane. The only point I am trying to get here is I think probably we have some rather fundamental differences on our conception of how society should be run and I just wanted to get that point out, because if you are starting out with the assumption that you have a right to all these things without regard to tests, then presumably somebody has to be providing all these things and if you are going to guarantee, without any consideration of income, what you put into it such as you are going to have the right to education, health, housing, food, transportation, what-have-you, it is a different kind of world than the one I would like to live in, to be honest with you.

Mr. CLAYMAN. Let me make a quick point, because we are on an esoteric course here.

Mr. CRANE. But this is your basic assumption.

Mr. CLAYMAN. Let me make it clear, I am not talking about any impractical, beyond the reach, totally idealistic notion. When I talk, when you talk, in this committee of a program such as H.R. 21, we are talking about a very practical, in my judgment, a very reachable and attainable program, which incidentally, beside all of the statistics I have heard, the one preeminent fact remains that most of the people in America want it and they have said so in all kinds of polls.

So I want it clear that our discussion does not, cannot be interpreted as one that is unrealistic and beyond the keen of humankind.

Mr. CRANE. My time unfortunately has expired. Thank you.

[The following was submitted for the record:]

SUPPLEMENTAL STATEMENT OF JACOB CLAYMAN, SECRETARY-TREASURER, INDUSTRIAL UNION DEPARTMENT, AFL–CIO

In my testimony of November 11, 1975 before the Subcommittee on Health of the Ways and Means Committee on National Health Insurance I reported a specific case in which the costs for normal birth involving a 6-day hospital stay was somewhat in excess of $600. I used this case which was reported to me by a friend to indicate the exorbitant cost under our present system of delivering health care.

Congressman Crane of Illinois expressed some doubt about the size of this hospital bill indicating that in his own family the cost for a normal baby delivery several years ago was much less.

I promised that I would make the actual facts known to the Committee in order to support my allegation. I have since learned that the case which I alluded to was inaccurately reported to me and therefore to the Committee. In fact, the hospital stay was *only five days* (not six) and the actual hospital cost for a normal delivery was $1,477.26. I am enclosing a copy of the actual bills presented to the father of the baby, however, I have expunged his name. This statement should dispell Congressman Crane's belief that the figures I cited in the hearing were perhaps exaggerated. The plain, simple and brutal fact is that for the average middle-class family even conventional costs, such as childbirth, are no longer bearable.

In my testimony I also indicated that even though the American consumer and the government spend an abormal share of our gross national product on health care, the results therefrom are less than satisfactory. I pointed out that in the area of infant mortality we rank below many other countries which spend considerably less on health than we do. Congressman Crane was dubious about this allegation and I indicated that I would submit further proofs.

I am attaching excerpts from an article by Frank Falkner which appeared in Children, May–June 1970, as follows:

"Much has been written about whether comparisons between countries' infant mortality rates are valid or whether it is fair to compare the high rate in the U.S. with Sweden's, which in 1967 was 12.9, the lowest rate reported for that year to the United Nations. The validity is questioned since Sweden has a small population, a high standard of living in all social classes, and a national health service. But these differences are exactly the reasons the figures of the various nations should be compared. How does Sweden achieve such an admirably low rate? Careful examination of all the factors involved, and assessment of their relative importance, will lead us not only to self-examination, but will indicate the priorities for attack.

"Some medical people say that comparisons between United States and Sweden figures are not valid because in Sweden 'a birth need not be reported until up to 5 years after the event.' This statement has no basis in fact. All births and deaths in Sweden must by law be reported within 24 hours. Moreover, epidemiologists are careful to examine the facts when international comparisons are made to find out whether adjustments or care in drawing conclusions may be necessary. Even if the statement were true, however, there would still be a basis for comparison. In Sweden, 98 percent of the births occur in hospitals, a situation that allows of reliable data collection.

"Reporting of accurate data, collection of such, and definitions are obviously important if international comparisons are to be statistically sound. Some countries—particularly the developing countries—do not have the wherewithal to collect accurate figures. We guess at their infant mortality rates as best we can. But largely owing to standard set by the World Health Organization, many countries of significant size and variation do collect and report their data in such a way as to make comparisons generally valid and proper.

"Some countries are said to consider a baby who does not live for 24 hours as stillborn, and it is sometimes implied that this birth would be reported as live in the United States of America. But would it? The United States has many rural and underprivileged urban areas where similar births are regarded as stillborn and where data is thus suspect. Were data in such areas accurate, it is virtually certain that our own infant mortality rate would be higher than our present estimate. This of course would also be true in some other countries.

"There is another point involved. The infant mortality rate in the United States has indeed been improving, but only very slowly, in the last 15 years. The slope of decline is virtually the same in many countries other than the United States even though their rates may be better or worse than ours. But the annual rate of improvement has been faster in other countries than in the United States.

"Priorities for intervention have to be set, for resources are limited, even in a wealthy country. Two goals, however, are essential: (1) Bringing about changes in the social structure to eliminate underlying socioeconomic problems in infant mortality and morbidity—a long-range preventative goal; and (2) bringing about an immediate decrease in neonatal deaths and an increase in intact survival by making intensive obstetric and neonatal care available to all who need it. Infant mortality rates can be reduced rapidly by 40 to 60 percent in parts of the United States where they are lamentably high, through application of present knowledge and through the expansion of comprehensive maternal and child health services."

Also see publication National Center for Health Statistics, series 3 # 6, U.S. Department of Health, Education and Welfare Public Health Service, for the following excerpts re infant mortality:

"Examples of such parallel activities are notification of stillbirths by physicians in hospitals or by midwives to health agencies in Denmark and Norway, and notification of stillbirths by midwives in the Netherlands. These parallel activities are used as cross-checks to assess the completeness of notification and registration. In the United States, medical and legal purposes are accomplished by a single document, and ongoing opportunities for cross-checks are limited."

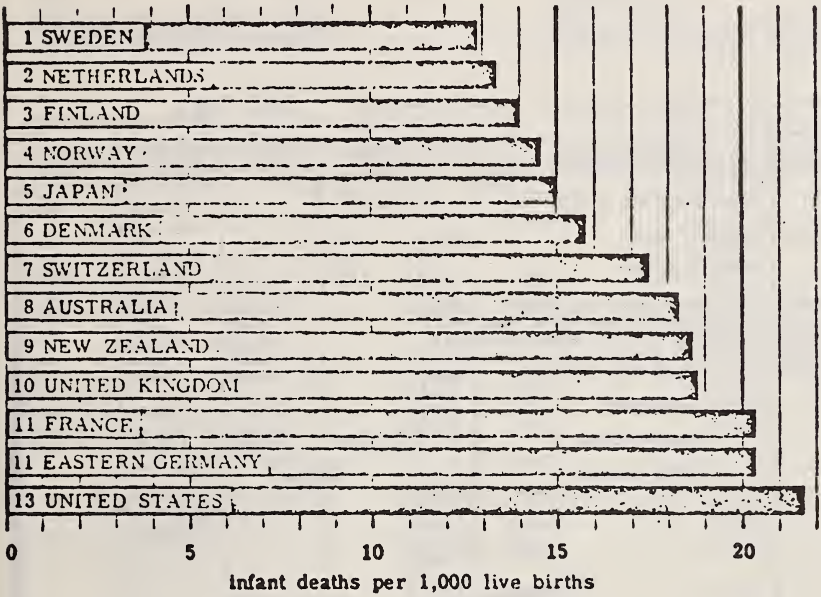
RELATIVE IMPORTANCE OF DIFFERENCES

"Each of the sources of difference in the basic data was considered independently by the participants at the conference held in Washington in May 1965. Where estimates of their statistical effect existed, it was felt that they were not sufficiently large to account for the observed differences in mortality. In some instances where evidence was unavailable, e.g. completeness of registration, it was pointed out that internal cross-checks and the impetus of social insurance benefits favored complete registration among the west European countries.

"The estimates presented here will be referred to again as the mortality data are presented. Their magnitude will be considered in the light of their relationship to the observed differences between the infant morality experience of the United States and the other countries."

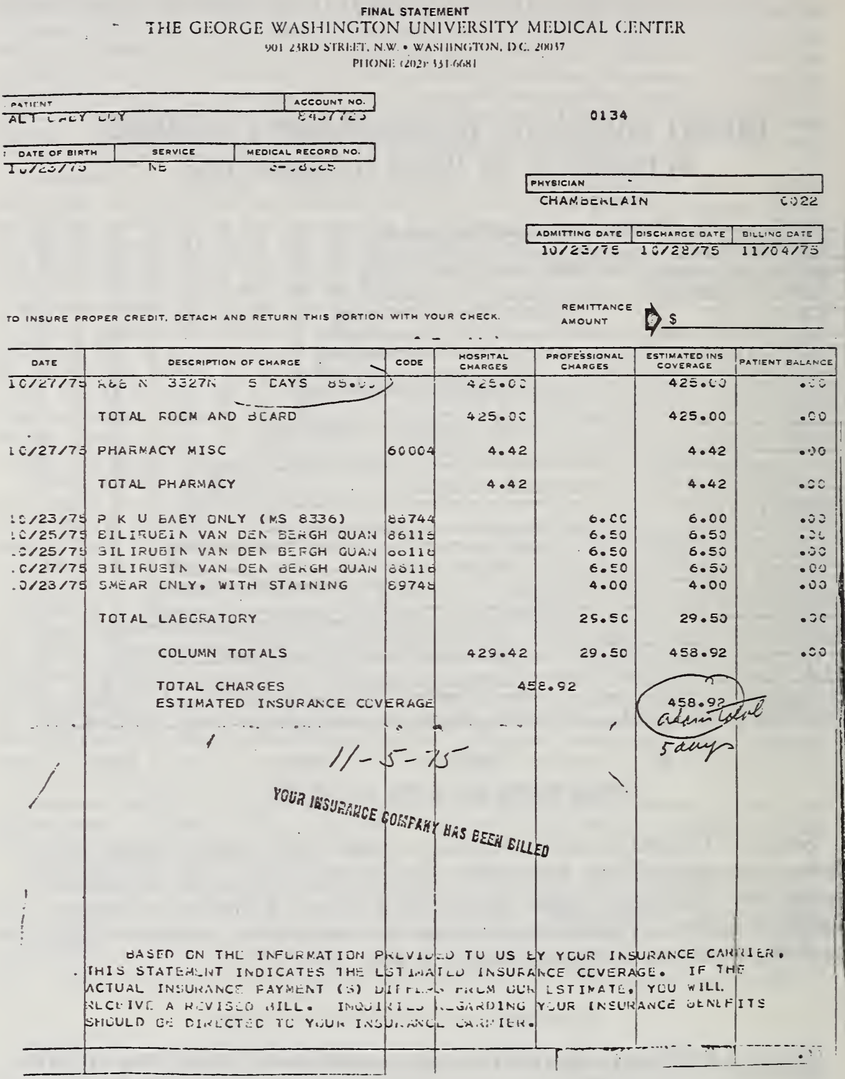
* * *

INFANT MORTALITY IN COMPARABLE NATIONS
as reported to the United Nations in 1968



Source: United Nations Demographic Year Book, 1968. The rates represented are for 1967, except those for the following countries: Finland, New Zealand, United Kingdom, France, Eastern Germany, and the United States, which are for 1968; and the rate for Norway, which is for 1966.

* * *



FINAL STATEMENT

THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

901 23RD STREET, N.W. • WASHINGTON, D.C. 20037

PHONE (202) 331-6681

PATIENT	ACCOUNT NO.
ALT BABY BOY	8457725

DATE OF BIRTH	SERVICE	MEDICAL RECORD NO.
10/23/75	NB	[illegible]

0134

PHYSICIAN	
CHAMBERLAIN	0022

ADMITTING DATE	DISCHARGE DATE	BILLING DATE
10/23/75	10/28/75	11/04/75

TO INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION WITH YOUR CHECK.

REMITTANCE AMOUNT $

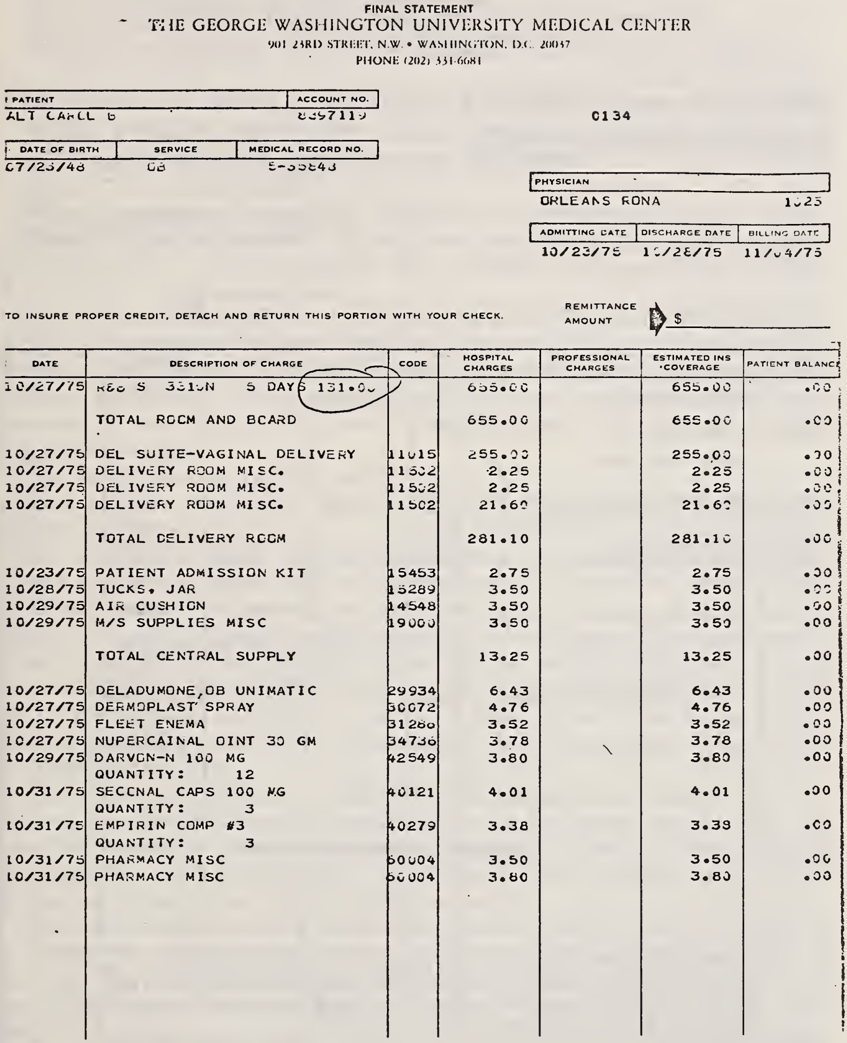
DATE	DESCRIPTION OF CHARGE	CODE	HOSPITAL CHARGES	PROFESSIONAL CHARGES	ESTIMATED INS COVERAGE	PATIENT BALANCE
10/27/75	RBB N 3327N 5 DAYS 85.00		425.00		425.00	.00
	TOTAL ROOM AND BOARD		425.00		425.00	.00
10/27/75	PHARMACY MISC	60004	4.42		4.42	.00
	TOTAL PHARMACY		4.42		4.42	.00
10/23/75	P K U BABY ONLY (MS 8336)	86744		6.00	6.00	.00
10/25/75	BILIRUBIN VAN DEN BERGH QUAN	86115		6.50	6.50	.00
10/25/75	BILIRUBIN VAN DEN BERGH QUAN	86116		6.50	6.50	.00
10/27/75	BILIRUBIN VAN DEN BERGH QUAN	86116		6.50	6.50	.00
10/23/75	SMEAR ONLY, WITH STAINING	89748		4.00	4.00	.00
	TOTAL LABORATORY			29.50	29.50	.00
	COLUMN TOTALS		429.42	29.50	458.92	.00
	TOTAL CHARGES		458.92			
	ESTIMATED INSURANCE COVERAGE				458.92	

above total
5 days

11-5-75

YOUR INSURANCE COMPANY HAS BEEN BILLED

BASED ON THE INFORMATION PROVIDED TO US BY YOUR INSURANCE CARRIER, THIS STATEMENT INDICATES THE ESTIMATED INSURANCE COVERAGE. IF THE ACTUAL INSURANCE PAYMENT (S) DIFFERS FROM OUR ESTIMATE, YOU WILL RECEIVE A REVISED BILL. INQUIRIES REGARDING YOUR INSURANCE BENEFITS SHOULD BE DIRECTED TO YOUR INSURANCE CARRIER.



FINAL STATEMENT
THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER
901 23RD STREET, N.W. • WASHINGTON, D.C. 20037
PHONE (202) 331-6681

PATIENT	ACCOUNT NO.
ALT CAROL B	8397119

0134

DATE OF BIRTH	SERVICE	MEDICAL RECORD NO.
07/23/48	OB	5-55843

PHYSICIAN	
ORLEANS RONA	1025

ADMITTING DATE	DISCHARGE DATE	BILLING DATE
10/23/75	10/28/75	11/04/75

TO INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION WITH YOUR CHECK.

REMITTANCE AMOUNT $ ____________

DATE	DESCRIPTION OF CHARGE	CODE	HOSPITAL CHARGES	PROFESSIONAL CHARGES	ESTIMATED INS •COVERAGE	PATIENT BALANCE
10/27/75	R&B S 331ON 5 DAYS 131.00		655.00		655.00	.00
	TOTAL ROOM AND BOARD		655.00		655.00	.00
10/27/75	DEL SUITE-VAGINAL DELIVERY	11015	255.00		255.00	.00
10/27/75	DELIVERY ROOM MISC.	11502	2.25		2.25	.00
10/27/75	DELIVERY ROOM MISC.	11502	2.25		2.25	.00
10/27/75	DELIVERY ROOM MISC.	11502	21.60		21.60	.00
	TOTAL DELIVERY ROOM		281.10		281.10	.00
10/23/75	PATIENT ADMISSION KIT	15453	2.75		2.75	.00
10/28/75	TUCKS, JAR	15289	3.50		3.50	.00
10/29/75	AIR CUSHION	14548	3.50		3.50	.00
10/29/75	M/S SUPPLIES MISC	19000	3.50		3.50	.00
	TOTAL CENTRAL SUPPLY		13.25		13.25	.00
10/27/75	DELADUMONE,OB UNIMATIC	29934	6.43		6.43	.00
10/27/75	DERMOPLAST SPRAY	50072	4.76		4.76	.00
10/27/75	FLEET ENEMA	31286	3.52		3.52	.00
10/27/75	NUPERCAINAL OINT 30 GM	34736	3.78		3.78	.00
10/29/75	DARVON-N 100 MG QUANTITY: 12	42549	3.80		3.80	.00
10/31/75	SECONAL CAPS 100 MG QUANTITY: 3	40121	4.01		4.01	.00
10/31/75	EMPIRIN COMP #3 QUANTITY: 3	40279	3.38		3.38	.00
10/31/75	PHARMACY MISC	60004	3.50		3.50	.00
10/31/75	PHARMACY MISC	60004	3.80		3.80	.00

FINAL STATEMENT

THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

901 23RD STREET, N.W. • WASHINGTON, D.C. 20037
PHONE (202) 331-6681

PATIENT	ACCOUNT NO.
.LT CAROL B	8597119

C134

DATE OF BIRTH	SERVICE	MEDICAL RECORD NO.
7/23/48	OB	5-35848

PHYSICIAN	
ORLEANS RONA	1025

ADMITTING DATE	DISCHARGE DATE	BILLING DATE
10/23/75	10/28/75	11/04/75

D INSURE PROPER CREDIT, DETACH AND RETURN THIS PORTION WITH YOUR CHECK.

REMITTANCE AMOUNT $ ____________

DATE	DESCRIPTION OF CHARGE	CODE	HOSPITAL CHARGES	PROFESSIONAL CHARGES	ESTIMATED INS COVERAGE	PATIENT BALANCE
	TOTAL PHARMACY		36.98		36.98	.00
0/23/75	NO PROFESSIONAL ANESTH CHG	06916				.00
	TOTAL ANESTHESIA					.00
0/23/75	CBC (HEMOGRAM) MCV-MCHV ROUT	86280		6.50	6.50	.00
0/23/75	ROUTINE SEROLOGY VDRL	86611		4.50	4.50	.00
0/23/75	URINE,CHEM & MICROSC,ROUTINE	89334		4.00	4.00	.00
0/24/75	HEMATOCRIT-PCV	86819		4.00	4.00	.00
0/27/75	COOMBS PROCEDURE	86603		6.50	6.50	.00
0/27/75	TYPING, ABO AND RH	87403		6.50	6.50	.00
	TOTAL LABORATORY			32.00	32.00	.00
	COLUMN TOTALS		986.33	32.00	1,018.33	.00
	TOTAL CHARGES		1,018.33			
	ESTIMATED INSURANCE COVERAGE				1,018.33 Carol 5 days	

11-5-75

YOUR INSURANCE COMPANY HAS BEEN BILLED

BASED ON THE INFORMATION PROVIDED TO US BY YOUR INSURANCE CARRIER, THIS STATEMENT INDICATES THE ESTIMATED INSURANCE COVERAGE. IF THE ACTUAL INSURANCE PAYMENT (S) DIFFERS FROM OUR ESTIMATE, YOU WILL RECEIVE A REVISED BILL. INQUIRIES REGARDING YOUR INSURANCE BENEFITS SHOULD BE DIRECTED TO YOUR INSURANCE CARRIER.

.00

Mr. Rostenkowski. Are there further questions of the witness? If not, thank you, Mr. Clayman.

Dr. Novello, Miss Griffith, please.

Would you identify yourselves and proceed with your testimony.

STATEMENT OF ELSIE I. GRIFFITH, R.N., CHAIRMAN, COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES OF THE NATIONAL LEAGUE FOR NURSING

Miss Griffith. I am Elsie Griffith, the executive director of the Visiting Nurse Association, a medicare certified home health agency in Dallas, Tex. Unfortunately, Dr. Novello was grounded in Erie, Pa., so she is unable to appear.

Mr. Rostenkowski. Are you going to testify for her, Miss Griffith?

Miss Griffith. I think that her written testimony which is the league's position on the major issues of a national health insurance system, and mine, which is specifically directed to home health benefits, are in your hands. If it is all right with you, I will just go on with my presentation.

Mr. Rostenkowski. Very well.

Miss Griffith. I will be glad to answer any questions you may have on her testimony.

Mr. Rostenkowski. We will place both the testimony of you and your associate in the record in their entirety.

Miss Griffith. There is no question in our minds about whether or not to have national health insurance, but rather the question is, what benefits will be included. One of the major provisions in any national health insurance system must be coverage for home health care coverage. I would like to discuss a little about what home health care is, why it is currently underutilized, and recommend ways it can be used in the future.

The types of services provided by our agency are varied. For instance, we provide care to people who are at home, people who are heart or cancer or stroke victims. The cost of care for these patients average about $6 to $8 a day compared to institutional care, which ranges anywhere from $400 to $800 a month.

We also provide services to families with mentally retarded children or adults to enable them to keep that person at home instead of putting the individual in an institution, where the minimum cost would probably be about $250 a month. With our service, the total cost of helping the family keep that individual at home is about $200 a month.

Our agency has a nurse liaision working inhospital with doctors and other hospital personnel, to help plan early discharge plan for patients. Our experience indicates that in most instances the person is saved at least a week of hospitalization and in Dallas hospitals, the average daily charge is $77.

We also have geriatric nurse clinics where currently we see about a thousand patients a month. The goal of these clinics is to help prevent stroke and whenever one older American is prevented from having a stroke, we save tremendous cost, hospital, doctor, and nursing home.

Another kind of service is adult rehabilitative day care. This is a program where a disabled person can come to a community center thereby enabling other members in the family to continue their jobs.

I don't know if you are aware how little home health service are currently being used. For example, in each of the last 5 years less than 1 percent of the total medicare dollar and even less than that of the medicaid dollar has been expended for home health.

In trying to analyze why this service has been so underutilized, it appears to us that there are several reasons. One, for instance is that if a hospital is operating at a 65 percent bed capacity, there is no real incentive to discharge the patient. Another factor is that doctors can stop by to see the patient every day in the hospital; this is not so easily possible when the patient is at home.

Also, it appears that since 1966 each time Congress was interested in reducing the medicare or medicaid dollar, the place they cut was home care, which to me is like General Motors doing an austerity budget and watching their paper clips because you could cut out all of home care and not affect the medicare dollar really.

We would like to recommend some proposals that would help to provide some incentives to increase the utilization of this less costly service. One of those recommendations is that prior hospitalization not be a requirement before a person is eligible for home care—this is probably one area that is most open to abuses.

Another recommendation is not to have either coinsurance or deductible for the lower cost service, such as home care, but to include coinsurance and deductible for the higher cost institutional service. This would encourage the consumer to demand service for which he has no out-of-pocket expense, and which is less costly to the Government.

We recommend also—that before a claim is paid for the higher cost service a test is made to be sure that the less costly services had been looked at and either found not appropriate or not available.

Another recommendation is that in any national health insurance plan, the benefits be measured with and interwoven with title XX so that both national health insurance and title XX, working together, could produce less cost.

A final recommendation is to reward families who are trying to take care of the sick person at home. They are participating in health care. The reward should enable them to have home backup support services that are necessary for them to continue to care for the people at home.

I think that is really the basis of what I wished to say. If you have any questions, I would be happy to answer them.

[The prepared statements and attachments follow:]

Statements of Dorothy J. Novello, Ph. D., R.N., President, and Elsie I. Griffith, R.N., Chairman, Council of Home Health Agencies and Community Health Services on Behalf of the National League for Nursing

Summary of Recommendations

Benefits: Comprehensive universal coverage and emphasis on preventive services.

Organization of services: Provision for adequate primary care services throughout the country; incentives for the development of non-institutional community services; development of quality and cost controls; state ad local planning a mechanisms with reasonable autonomy; and administration of program by a single federal agency.

Financing: Use of variety of sources.

Manpower: Provision for increase of health manpower; funding for health manpower education; reimbursement for nursing services; and nursing participation at all levels of decisionmaking in a national health insurance system.

Consumer participation: Consumer participation at all levels of decisionmaking in a national health insurance system.

Mr. Chairman, Members of the Committee, I am Dorothy Novello, President of the National League for Nursing. With me is Elsie Griffith, Chairman of the League's Council of Home Health Agencies and Community Health Services.

The National League for Nursing is a coalition of 1 800 nursing education and nursing service agencies and 15,000 individual members—nursing, leaders other health professionals, and consumers—who work together to improve the quality of nursing education and nursing service in the United States.

The Council of Home Health Agencies and Community Health Services is a component of the League which represents agencies certified to deliver and be reimbursed for home health services furnished to Medicare and Medicaid patients.

I will present to you the League's position on the major issues of a national health insurance system, and Ms. Griffith will present a proposal for a home health benefits package which we recommend be made part of a national health insurance system.

The National League for Nursing supports the expeditious development of a national health insurance system which will restructure the delivery of health care services and provide equal access to health care for all citizens.

BENEFITS

The NLN believes that such a national health insurance system should provide comprehensive universal benefits for all citizens, regardless of age or income. A comprehensive benefits package should include the following full range of services for all physical and mental care: Preventive services, health maintenance, diagnosis, treatment, and rehabilitation.

Such comprehensive universal coverage would place considerable demand on the health and financial resources of the country. Therefore, we believe that such benefits should be gradually phased into the insurance system. The League has developed a set of minimum benefits which we believe should be provided in the initial phase. I have attached a list of these benefits to my written statement.

One component of the benefits package to which I wish to call special attention is *preventive* health care services. I believe that the greatest potential for improving the health of the citizens of this country is to teach and motivate people to lead healthy lives. Without special emphasis on preventive care, the national health insurance system will not improve the health status of the country.

Recently I served on the Task Force on Consumer Education sponsored by the American College of Preventive Medicine and the Fogarty Center of the National Institutes of Health. The mortality data collected for our study shows a preponderant incidence of preventable causes, generally not of the kind that lend themselves to medical care.

The problems appear to lie primarily in different health habits and lifestyles of individuals, not in the amount of medical care they receive. Documentation on the relationship between death rates, health status and lifestyle is accumulating at a rapid rate.

Yet national health policy has been slow in responding to the need for preventive care. Of the total current budget for health care in the country, only 2–2½ percent goes for preventive measures, and ½ percent for health education.

ORGANIZATION OF SERVICES

The NLN believes that the national health insurance system should be organized to make primary care services readily available at all times, within a citizen's own locality. Primary care services should include the professional management of a full continuum of health care for the individual and his/her family.

The insurance system should provide incentives for the development of less-costly, non-institutional community health services so that citizens can receive care at home or near home on an out-patient basis, when feasible. The system should be designed to allow the individual's needs govern where and what types of care the individual receives.

Such a system must have built-in controls to check the quality, efficiency and cost of the services and the utilization of facilities and manpower. Federal funds should be made available to develop the technical capabilities for monitoring services, facilities and manpower.

The national health insurance system should encourage the development of alternative forms of health care delivery. A federal research and demonstration program should be established for this purpose.

Mechanisms for effective local and state health care planning should be made an integral part of the national health insurance system. To operate effectively within a locality or state, the health planning units must be given reasonable autonomy.

The actual administration of the health insurance system should be the responsibility of a *single federal* agency. Experience with Medicare and Medicaid has proven a costly duplication of administrative and supervisory services.

FINANCING

A comprehensive benefits package with adequate cost and efficiency controls would be a continual major financial investment for the country and its taxpayers. The NLN believes that the financing of such a national health insurance system should be distributed equitably among the population.

Federal funds should be raised to finance services for the low-income and elderly populations, and to partially finance services for the middle and high-income populations. The funds should be raised through a variety of means, including payroll taxes and general revenues.

We must however, not over-rely on general revenues. The current fiscal plight of Great Britain's National Health Service should serve as a warning to us. Three-quarters of the total National Health Service budget comes from general taxes. In tough economic times such as these, health care services in Great Britain have to compete with many other services for part of the shrinking budget. I believe that health care should not be subjected to such economic fluctuations.

MANPOWER

Increased demand for health services which will be triggered by a national health insurance system must be accompanied by a commensurate increase in the supply of qualified health professionals. A careful assessment must be made of the types of health professionals that can best deliver the various services needed.

All health professionals should be utilized at their highest level of espertise. Health professional schools must be expanded and strengthened to prepare practitioners for the demands of the system. Progressive curricula must be developed for basic, advanced, and continuing education. Federal support for health professional education will be essential.

The nursing profession has already begun to expand its professional role to provide needed services. The results, in terms of quality of care have been favorable.

In the future, many more nurses with appropriate education will become highly specialized in a variety of areas of health care delivery. Within primary care, nursing practice will be focused on problems of specific population groups, such as pediatrics and geriatrics. And nursing's role will also continue to expand in the traditional areas of acute care and rehabilitative care.

Nurses who are assuming these expanded responsibilities are practicing more independently. Commensurate with this independence is the greater degree of decision making and direct accountability to the client for care provided. Reimbursement for these services should reflect this independence. Therefore, the NLN believes that the reimbursement for these types of nursing services should be as clearly identified and delineated as payment for the services of physicians and dentists.

Nursing expertise has become an important component in the management of health care, and as such nursing input is important in health planning and regulation. NLN believes that qualified nurses in active practice should be included at all decision-making levels in a national health insurance system.

CONSUMER PARTICIPATION

The national health insurance system should be designed to be accountable to the public. The federal agency administering the program should be accountable to the Congress and to consumers through well-defined review, grievance and appeal procedures. We believe that consumers should participate in the national health insurance system at all decision-making levels.

Mr. Chairman, thank you for the opportunity to present the NLN's position on a national health insurance system. I will be glad to answer any questions or provide any further information you wish.

MINIMUM BENEFITS FOR A NATIONAL HEALTH INSURANCE PROGRAM

[The National League for Nursing recognizes the goals of the national health insurance program as outlined in its position statement cannot be reached in an initial phase of the program. The league believes that the minimum benefits for an initial program include the following]

Institutional services	Out-of-institution services	Independent practitioner services	Prescribed[1] materials
Coverage for:	Coverage for:	Coverage for:	Coverage for:
Acute hospitalization.	Home health agency services.	Those professional services currently covered under Medicare B.	Drugs.
Skilled nursing home care.	Ambulatory center services.	Nursing services for primary care.	Devices and supplies.
Rehabilitation facility care.	Out-patient services.	Dental services for children.	Eyeglasses.
			Transportation.[2]

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[1] Prescribed by appropriate health professionals.

[2] Including emergency transportation.

COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES, NATIONAL LEAGUE FOR NURSING

SUMMARY OF RECOMMENDATIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER NATIONAL HEALTH INSURANCE

1. No prior hospitalization.
2. No visit limitation.
3. No deductible.
4. No coinsurance.
5. Certificate of need.
6. One set of certification standards.
7. NLN–APHA accreditation in lieu of certification.
8. Grant monies for expansion of home health services.

Mr. Chairman and Members of the Committee, I am Elsie Griffith and, in addition to being Chairman of the Council of Home Health Agencies and Community Health Services, I am Director of the Visiting Nurse Association in Dallas, Texas. The V.N.A. is a community based certified home health agency employing a multidisciplinary staff of nurses, home health aides, physical therapists, speech pathologists, occupational therapists and social workers.

Home Health Services

Home health services are that component of comprehensive health care which provides health services to individuals and families in their places of residence for the purpose of promoting, maintaining or restoring health, or minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient and family are planned, coordinated and made available by an agency organized for the delivery of health care through the use of employed staff, contractual arrangements, or a combination of administrative patterns.

These services are provided under a plan of care which includes appropriate service components such as, *but not limited to*, medical care, dental care, nursing, physical therapy speech pathology, occupational therapy, social services, nutrition, homemaker-home health aide services, transportation, laboratory services, medical equipment and supplies.

Home health services in the system

Home health services are the most effective therapeutic mode of treatment and the most economical means of treatment for many patients in the health care system. Properly coordinated and administered home health care provides a meaningful health service for ill persons, speeds recovery and rehabilitation of individuals with acute or chronic health problems, and assists in the prevention of disease and disability.

In addition, there are many people, particularly among the elderly and chroniaclly ill, who have little prospect for total recovery but who have the need for part-time nursing observation, preventive and restorative services. If home health services are denied to these individuals, the result is often that the individual will eventually be placed in a hospital or nursing home at a much higher cost.

The economics of home health care is documented in the attached news release, "A Dramatic Difference in Cost: Home Health Care Versus Institutional Care."

For some patients, institutional care in long-term care facilities is the alternative to home health services. The shortcoming of these institutions is documented in a publication of the Department of Health, Education, and Welfare, "Long-Term Care Facility Improvement Study."

For other patients the alternative to home health services is inpatient hospital care. The cost/benefit comparison with respect to either alternative is convincing evidence that the role of home health services in the health care system must be expanded and encouraged.

Past is prologue

Home health services are poorly utilized under Medicare and Medicaid; they account for less than 1 cent of the Medicare dollar and less than one-half cent of the Medicaid dollar. The reasons for this poor utilization should be thoroughly investigated and understood prior to the adoption of provisions relating to home health services under national health insurance. The mistakes of the past must not be perpetuated in the future if we are to make needed improvements in the health care delivery system.

Recommendations

In adopting provisions related to home health services coverage under national health insurance, the Congress should give consideration to these subjects: conditions of eligibility for home health services; scope of home health services eligible for reimbursement; conditions of and limitations on payment for services; incentives toward increased utilization; standards of quality health care, and certificate of need.

The Council has prepared a proposed home health benefit package which is appended in its entirety to this testimony. We firmly believe that home health services must be accessible to everyone. The major recommendations contained in this benefit package are:

1. Prior hospitalization shall not be a requirement for home health services;
2. There shall be no limitation on the number of visits an individual may receive;
3. No deductible for home health services;
4. No coinsurance for home health services;
5. Certificate of need must be a requirement for the establishment of a new agency;
6. One federal regulatory agency must establish one set of certification standards for participating agencies. These standards must be no lower than the basic minimum now required for Medicare certification;
7. NLN-APHA accreditation should be accepted in lieu of certification. The standards for this accreditation program are higher than the basic minimum now required for Medicare certification; and
8. Mechanism should be established for expansion of the home health field through grant monies, to ensure home health coverage in underserved areas and for broadening the array of services needed by home care patients.

In summary, the community, rather than the institution, should be the primary site of care. Home health services should not be thought of as an alternative method of care. The array of services provided within the community should make appropriate choices of care possible.

PROPOSED HOME HEALTH BENEFIT PACKAGE, COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES

INTRODUCTION

Home health services of good quality are an essential part of the health care system. The home environment plays a significant role in promoting health and facilitating the healing process. The caring family can become an integral part of the health services team. Home health services, appropriately articulated with other health and social services—institutional and ambulatory—provide an economical and desirable way of meeting many of the health care needs of society, both preventive and curative.

Home health services must be available to all people without regard to age, sex, race, creed, national origin or prior health care in an institution, i.e., hospital. These services must include all components necessary to insure the health and safety of those for whom such services are appropriate.

Home health services which should be reimburseable under a health insurance program are those which:

Are essential to the rehabilitation and recovery of the patient;

Are necessary to prevent deterioration of the patient's condition;

Sustain the patient's current capacities even when full recovery or medical mprovement is not imminent; and

Promote health and prevent disease or its progression.

HOME HEALTH BENEFITS

Benefits for the following home health services are available through a participating home health agency (see attachment for description of a home health agency):

1. Nursing service (provided by a registered professional nurse or licensed practical nurse under supervision of RN);
2. Homemaker-home health aide service (under supervision of the appropriate agency professional);
3. Physical therapy service;
4. Occupational therapy service;
5. Speech pathology service;
6. Social work service;
7. Services of a nutritionist;
8. Medical supplies and equipment (including drugs and biologicals);
9. Laboratory, X-ray, and EKG services;
10. Respiratory therapy service;
11. Transportation service to the medical, rehabilitative, and restorative services when provided or contracted for by the home health agency; and
12. Physician service, dental service and podiatry service as are furnished by the home health agency for the care and treatment of an individual.

NOTE.—Any of the foregoing items and services which are provided on an outpatient basis, under the arrangements made by the home health agency, at a hospital or extended care facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and (a) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in his place of residence, or (b) which are furnished at such a facility while he is there to receive any such item or service described in clause (a), excluding however, any item or service if it would not be included if furnished to an inpatient of a hospital.

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

In the case of home health services, such services are or were required because the individual is or was essentially homebound (but who may leave his residence periodically to obtain health services pursuant to the plan of treatment) and is or was in need of home health services on a visiting basis where such services are or were required to be given to meet the individual's medical treatment and/or diagnostic needs; a plan for furnishing such services to such individual has been established and is periodically reviewed by the agency and the physician; and such services are or were furnished while the individual was under the care of a physician.

Eligibility for home health services is predicated on the patient's need for nursing, physical therapy, speech pathology, or homemaker-home health aide services. The latter shall be rendered under the supervision of appropriate agency health professional.

Home health services are part-time and intermittent in nature (except in unusual circumstances and for a limited time, e.g. when institutional care is needed but cannot be arranged immediately or when up to 24 hour per day home health care is needed for a short duration only) as subject to regulations by the Secretary.

SCOPE OF BENEFITS

When home health care is initiated there is usually an impact period when a broad array of home health services should be available to the patient. A continuing care period commonly follows resolution of the acute phase of the patient's illness when home health services continue to be needed but at a reduced intensity.

However, the patient's condition, which may fluctuate, dictates the intensity and array of services provided; and when care is provided for the terminally ill patient, the degree of care intensity may be expected to increase rather than decrease.

Benefits for all home health services shall be available for an initial period of 60 days. Continuation of benefits after that period must be recertified by the patient's physician and the provider agency through a system of concurrent utilization review.

COINSURANCE AND DEDUCTIBLE

Home health services are not subject to deductibles or coinsurance payments. Costs of administering a coinsurance requirement have been found to exceed the amount of coinsurance and other methods to prevent overutilization are more appropriate to home health services.

DEFINITIONS

Home Health Agency

The term "home health agency" means a public or private agency or a subdivision of such an agency or organization (including a home care department of a hospital) the need for which has been determined under "certificate of need" requirements and which:

1. Is primarily engaged in providing nursing and also provides homemaker-home health aide services and at least one of the following services: physical therapy, occupational therapy, speech pathology, nutrition, social work, which services should be available seven days a week;
2. Is responsible for planning, coordinating, and supervising the delivery of such services;
3. Has standards for the professional personnel providing home health services which are those established by the respective professional organization representing each. The registered professional nurse in the home health agency has the responsibility for:
   (a) Assessment of the total needs of the patient upon admission and at appropriate intervals subsequent to admission.
   (b) Planning and management of a patient care plan and coordination of needed services with concurrence of physician on medical aspects of the care plan, and
   (c) Observation and monitoring of the patient's responses to care and treatment and modification of the care plan accordingly.
4. Is licensed and/or certified by appropriate governmental agencies or is accredited by NLN–APHA as an agency and its services meet the standards of appropriate standard-setting bodies;
5. Has policies established by a governing body;
6. Has a professional advisory body including representatives of services provided and including members who are not members of the governing body or employees of the agency;
7. Provides for supervision in the care setting and coordination by the appropriate professional discipline;
8. Maintains clinical records on all patients;
9. Has a program of utilization review and control and quality assurance which meets established standards;
10. Has appropriate inter-agency transfer arrangements;
11. Has a program of staff development and a program of orientation of new employees and contractual staff members; these programs are incorporated in the agency's personnel policy;
12. May secure services by contract from other organizations, it retains responsibility for supervision and meets other conditions as in 10. above;
13. Has established policies and procedures for ongoing systematic evaluation of the total agency, revised as needed;
14. Has an annual operating budget which includes all anticipated income and expenses for operation of the agency adopted by the governing body.

Home Health Services

The term "home health service" is that component of comprehensive health care whereby services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health, or minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient and family are planned, coordinated and made available by an agency/institution, or a unit of an agency/institution, organized for the delivery of health care through the use of employed staff, contractual arrangements, or a combination of administrative patterns.

These services are provided under a plan of care which includes appropriate service components such as, *but not limited to*, medical care, dental care, nursing, physical therapy, speech pathology, occupational therapy, social work, niutrition, homemaker-home health aide, transportation, laboratory services, medical equipment and supplies.

A Dramatic Difference in Cost: Home Health Care Versus Institutional Care

Experts in the health industry have recognized home health care to be a less expensive and more effective means of providing health services to patients who do not need or who no longer need to be cared for in an institution.

In testimony before the Subcommittee on Health for the Elderly of the Senate Special Committee on Aging on July 12, 1973, Dr. Charles C. Edwards, Assistant Secretary for Health said, "There is no question . . . that the closer we could move health care to the people, the greater the effect it is giong to have on the overall cost of health care . . . We have to encourage the service that will push health care away from the hospital and closer to the home."

No nationwide survey has been done to prove the cost savings of home care as compared to hospitalization or confinement or a nursing home. However, several local studies have been made, and listed below are brief reports on some of them.

1. The Visiting Nurse Association of Boston, Mass. developed a home care program for Mr. B., a 74-year old man discharged home after two months in a small private hospital where he was treated for a stroke.

17 weeks intensive home care: Visits by nurse, physical therapist, speech therapist, occupational therapist, totalling 50 visits; visits by home health aide totalling 34 hours	$1,230
Equivalent hospital care 119 days: At $100 per day	11,900
On-going home maintenance care: One visit every 2 months by nurse, and 3 hours per week by home health aide	25,000
Equivalent nursing home care per week: At least	150

2. The Salt Lake City Community Nursing Service, Salt Lake City, Utah, took over the care of Mrs. N., in 1973. She had been transferred from a hospital in Phoenix to her daughter's home in Salt Lake City. Her diagnosis was stroke with paralysis and congestive heart failure, with "terminal" prognosis. Within five weeks, the 90-year-old lady was approaching maximum rehabilitation.

5 weeks intensive home care: Visits by nurse and physical therapist totalling 29 visits	$349.13
Comparable institutional care 35 days, per diem costs only:	
Hospital	2,695
Nursing home	875

3. In 1972, the Salt Lake City Community Nursing Service initiated a home care program for Mr. and Mrs. T., an 87-year old couple. Mrs. T. was totally blind, and Mr. T. was legally blind. Mrs. T. suffered her first stroke in 1969, was not hospitalized and was not referred for nursing home care. With home care treatment, Mrs. T. was maintained at home comfortably until her death on June 11, 1973.

160 days home maintenance care: Visits by nurse, social worker and home health aide totalling 42 visits	$399
Comparable institutional care 160 days, per diem costs only:	
Hospital	12,320
Nursing home	4,000

4. The Rochester, New York Home Care Association studied the results of early release of patients from hospitals to home health programs. Results showed an estimated reduction of 13,713 patient days and a savings of $1,055,000 in calendar year 1970: and an estimated reduction of 12,579 patient days and a savings of $1,068,000 in calendar year 1971.

5. The Denver Department of Health and Hospitals studied the results of its Early Hospital Discharge Program and showed a savings of $515,729 in hospital costs for Medicare patients in 1970 as a result of early discharge of 292 patients from hospitals to home care programs.

A report prepared for the Senate Special Committee on Aging in July 1973 ("Home Health Services in the United States: A Working Paper on Current

Status") included the following summary of the benefits of effective home health care programs:

1. Patients prefer care that can be provided in the normalcy of their home environment.
2. Home-bound people can be taught to live in a relatively independent status.
3. The need for initial admission or readmission to in-patient institutions can be diminished.
4. For the necessary institutional admission, unnecessary days can be eliminated through early discharge to home care.
5. Capital construction costs for in-patient facilities can be reduced.
6. The efficiency of the practicing physician can be increased by expanding the team approach.
7. Home care staff can readily interpret medical orders, explain treatment regimes and offer reassurance and support.
8. Home care staff can identify day-to-day problems and thus help to reduce the possibility of emergency situations arising.

The Council of Home Health Agencies and Community Health Services of the National League for Nursing is the national spokesman for home health agencies and community health services, and serves as the connecting link for 2,300 such agencies throughout the country. The National League for Nursing is a membership organization dedicated to meeting the nursing needs of the public by improving nursing education and nursing services.

"Best Seller" in Home Health Care for Over 40 Years—the VNA Story—Service is Still our Main Concern

WHAT IS THE VNA?

The Visiting Nurse Association of Dallas, founded in 1934, is a voluntary, non-profit agency providing health care and guidance to residents of Dallas and Kaufman Counties in their homes and/or in various group settings. From a minute staff offering home nursing care only, the organization has grown steadily and systematically over the four decades of its existence, adding services and staff according to the dictates of community health needs.

WHAT IS THE STAFF?

Today, Visiting Nurse Association of Dallas employs well over 300 regular staff members representing many professional disciplines, including, in addition to Nurses and Nurse Specialists, Medical Social Workers, Physical and Occupational Therapists and Speech Pathologists. Its Homemaker/Home Health Aides, instructed and supervised by the nursing and therapy staff, and a number of other reliable and experienced workers are available for different phases of the agency's specialized services.

HOW DO I ASK FOR CARE?

Most referrals come from doctors, hospitals and clinics. However, anyone may call directly on his own behalf, or for his child, parent, friend or neighbor. A home visit will be made to assess the situation and determine how the patient's needs can be met by the agency or by some other community resource.

WHO IS ELIGIBLE?

Anyone is eligible for service who has a health problem requiring home service, including nursing care. Certain treatments and medications, however, are given only when they can be carried out safely in the home and are ordered by a physician. If the person requesting care has no physician, the Visiting Nurse will help find a source of appropriate medical care in the community.

WHAT DOES A VISIT COST?

There is a charge for service based on what a visit actually costs the agency. Patients or their families are expected to pay for services when they are able to do so.

Using an established standard, the agency will adjust the fee when necessary, according to the family's income and expenses.

Payment for services

Full or partial payment by patient;
Health insurance;
Veterans Administration;
Medicare/Medicaid;
State Department of Public Welfare; and
United Way.
Fees are actual non-profit service costs.

WHAT HELP CAN THE VNA GIVE?

The Visiting Nurse Association is prepared to:

Provide whatever nursing is needed, including pediatric and geriatric care.

Teach patient or family members how to manage the care.

Change dressings, give injections and treatments ordered by the doctor.

Help patients with exercises prescribed by their doctors in collaboration with the agency's physical therapists.

Explain doctor's orders for treatments, special diets and medicines and report back to him as needed.

Lend Supportive guidance and supervision to psychiatric patients and their families, and to mentally retarded patients and their families.

Offer guidelines to good health practices.

Inform patients about other community agencies that can help in areas such as family planning, housing and employment.

Arrange for homemaker/home health aide service or for other components of the VNA Home Management program.

Furnish physical and occupational therapy and speech pathology.

Discuss eligibility of patients and families for other specialized services, such as Chore Service, Equipment and Supplies, Family Care, Meals on Wheels, Respite Care and Transportation.

CURRENT SERVICES

Nursing service: Home nursing, group nursing, and hospital liaison.

Home management service: Homemaker/home health aides, chore service (SSI recipients only), family care (SSI recipients only), and respite care (Dallas County residents certified eligible by Ft. Worth State School only).

Therapy service: Physical therapy, occupational therapy, speech pathology, medical social work, and behavior management.

Nutrition service: Meals-on-wheels, nutrition counseling, and consumer buying.

Personal care organization: Home health equipment, transportation, and adult rehabilitative day care.

Adult Rehabilitative Day Care—A Service of the Visiting Nurse Association

(A positive, creative community response to the needs of functionally and socially disabled adults and their families))

ADULT DAY CARE—IT MAY BE THE ANSWER

A short-term social and functional rehabilitation center in the community designed to:

Restore functionally and socially disabled adults to a level of performance consistent with independent living.

Serve as a testing ground to determine the most appropriate level of care for the patient.

Act as a buffer between institution and the community in order to determine the feasibility of return from institutional care and/or to ease the transition from long term institutional care to the community.

Assist the functionally and socially disabled individual in identifying appropriate and available social and health resources in the community.

Accept from hospital discharge units functionally or socially disabled patients who no longer require intensive treatment, but require regular nursing supervision and/or moderate non-physician therapy treatment.

Provide temporary relief from the burden of care to families of socially and functionally disabled persons.

SERVICES PROVIDED

Those accepted will have the opportunity to participate daily in an eight-hour program, offering the following components:

1. Medical component

Full-time registered nurse to supervise medication distribution, provide nursing care assessment and instruction.

Participants admitted after physical examination by their attending physician with his recommendations regarding limitations of activities, special diet, medications and prognosis.

Staff with first aid training and capability for recognizing symptons of distress in the population.

2. Rehabilitation component

Physical Therapy.
Occupational Therapy.
Speech Therapy.
Self-Care Training.
Orthopedic & Adaptive equipment.

3. Nutritional component

Special diet counseling/instruction.
Lunch and two snacks.

4. Social component

A pleasant, comfortable and safe environment.
Responsible and close supervision.
Social work counseling and group work.
Consumer education.
Personal hygiene counseling/instruction.
Laundromat.
Barber and beauty shop.
Accident prevention programs.
Reality orientation.
Gardening.
Legal consultation.
Money management programs.
Daily rest period.
Transportation to and from the center.
Participant Advisory Board.

HOW TO APPLY

Interested persons may call the Visiting Nurse Association's admissions office at (214), 369–5191 or write to: Thomas Duffy, Director, Personal Care Organization, Visiting Nurse Association of Dallas, 351 West Jefferson, Dallas, Texas 75208.

After the initial contact a nurse and social worker will visit the applicant's home.

POPULATION TO BE SERVED

Medical considerations

Under medical plan of person's private physician.
Low potential for rapid clinical deterioration.
Moderate to low need for nursing and/or other non-physician therapies.

Environmental considerations

Must have a home to return to at night.
Must have reached the age of 18 years.

Personal/social considerations

May have deteriorated or be in the process of deteriorating mentally or socially.
May be mentally retarded.
May exhibit difficult behavior.
May be a non-participant in own home.
May be confused, withdrawn, disorientated "senile," but must not be harmful to self or others.

Physical/functional considerations

May have suffered severe physical set-backs, such as stroke.

May be non-ambulatory but must not be bedridden.

May be incontinent.

May not be capable of adequately/independently performing activities of daily living.

Restoration considerations

Entry into the program is limited to those persons who have rehabilitative potential as determined by a multi-disciplinary team.

The Visiting Nurse Association.—A non-profit United Way Agency, was founded in 1934 and is certified by Texas State Department of Health for Medicare and Medicaid, National Council of Homemakers/Home Health Aides Inc.; endorsed by the Dallas County Medical Society; and a member agency of the Community Council of Greater Dallas. Other services of V.N.A. include: at home professional nursing care, geriatric nursing clinics, homemaker/home health aides, meals-on-wheels, non-physician therapies, home health equipment, and transportation.

Mr. ROSTENKOWSKI. Are there any questions of the witness?

Mr. Crane will inquire.

Mr. CRANE. Thank you, Mr. Chairman.

Miss Griffith, would you classify yourself as an expert on health care?

Miss GRIFFITH. I classify myself probably as an expert in the home care part of health care service.

Mr. CRANE. I wish Mr. Clayman has been here during this part of the program, because this was a subject we got into and I think you were here in the room before he left when I raised the question about longevity, which he used as a very vital criterian for determining quality of our health care system. This may not have been your testimony, but on page 4 there is reference to the mortality data collected from studies that show the preponderant incidence of preventable causes generally not of the kind that lend themselves to medical care. It gets into preventive medicine, which you endorse and which I agree with wholeheartedly, and you suggest in this testimony that the problems appear to lie in different health habits and lifestyles of individuals.

I think that your experience and the experience of the American College of Preventive Medicine and the Fogarty Center, National Institutes of Health, have put their finger on a very vitally significant point that is overlooked in these kinds of simplistic generalizations of why there are these differences in longevity rates. I commend you for that statement.

The only other thing I would ask you is do you subscribe to the basic assumptions that Mr. Clayman made reference to that health care is a right?

Miss GRIFFITH. Well, I subscribe and I think our constituency does, to the assumption that people who need health care deserve to have it available for them.

Mr. CRANE. That is a moral judgment I would make, too. The distinction I am trying to make is more than just quibbling over semantics, however, because to suggest that it is, indeed, a right it would extend to my "right" to lay claim to you; and that I reject on moral grounds amongst others. But I think that carrying that logic to its conclusion suggests that there are virtually all aspects of survival and my general welfare that if viewed as a right that I have to other people's services and goods, is to lead us down a garden path to a system that virtually all of us would find intolerable, which, however idealistic in motivation, has been, in fact, tried in other countries and proved wanting.

I cannot believe that a professional such as yourself with the training and commitment and dedication that you have made and other professionals in your field would subscribe to that as a basic assumption in advancing your argument, which may coincide with Mr. Clayman's, but I think an eminently more defensible point of view. I thank you for your testimony.

Miss Griffith. Well, I guess because we see so many people every day who need health services and who don't have it available to them—I guess I go back to when there is this need that it should be available to all of our people in some way.

Now, I also believe that in being able to fund health care, we are not talking, as the AMA was, about the highly technological advanced care, but rather we are just talking about something that is safe and good for people. That is a little different and has a different price tag.

Mr. Rostenkowski. Thank you, Miss Griffith.

Our next witness is Dr. Liebman.

Welcome to the committee. If you would identify yourself and your associate, you may proceed with your testimony.

STATEMENT OF JEROME LIEBMAN, M.D., ON BEHALF OF AMERICANS FOR DEMOCRATIC ACTION, ACCOMPANIED BY SAMUEL FIELDS, LEGISLATIVE REPRESENTATIVE

Dr. Liebman. Thank you very much.

I am Dr. Jerome Liebman. I am a professor of pediatrics at Case Western Reserve Medical School, director of pediatric cardiology. I am a consulting physician. During my years of practice I have participated in numerous committees and studies on the topic of national health insurance.

Appearing with me is Samuel Fields from the legislative department of the Americans for Democratic Action.

On behalf of Americans for Democratic Action I am honored to present our views on the subject of national health insurance.

Skyrocketing costs, cancellations in malpractice insurance, loss of health insurance by the growing numbers of unemployed are all evidence that the problems of economical and proper health care are no longer only problems of the poor and uninsured.

For medicare patients copayments have driven costs up to the point where the overall health care bill for this group is now greater than it was before the adoption of the medicare program in 1964. The lack of overall national planning has resulted in 100,000 empty hospital beds over and above the generous 15 percent reserve recommended by the Hill-Burton program.

So that the United States will have an affordable health care system which meets the needs of all Americans, I hope your subcommittee will incorporate the following features in any forthcoming legislation.

UNIVERSAL COVERAGE

Under the guise of so-called "freedom of choice" some people have suggested that membership in any national health insurance program should be on a voluntary basis. In the end, however, a system of voluntary membership will shortchange individuals and families with low or no income. These are the people that will be forced to make choices, for example, between the insurance payment and the rent, or the insurance payment and the grocery bill.

It is not a fair choice, and it ought not be faced by any American. The lack or inadequacy of health insurance coverage under the present system has made injury and illness one of the greatest sources of personal bankruptcy in the country. This situation benefits no one—neither the patient, nor his family, nor doctors, nor hospitals forced to treat the patient as a de facto charity case.

Some have proposed that the voluntary medical insurance be included, but with a means test we believe this would be demeaning to applicants. Everybody must be covered by virtue of being a human being.

EQUAL CARE FOR ALL

Although ADA would not oppose allowing additional private insurance for such luxuries as a private room, this must not interfere with the goal of a national health insurance program which permits doctors to make decisions on the basis of their patients' medical needs—not their pocketbooks.

Cost-sharing plans, which employ coinsurance or deductibles, are unacceptable. Proponents of such plans argue that cost-sharing plans are necessary to prevent wasteful overutilization of health facilities. Close investigation, however, shows that their concern is misplaced. The greatest amount of waste actually occurs because health facilities are underutilized.

Along with the multi-billion-dollar waste of 100,000 empty hospital beds is the enormous waste which results from needless duplication of costly equipment and services by hospitals seeking to become self-contained. In Boston, for example, six open heart units do the work of two, while consumers pay upkeep on all of them.

Deductibles often are presented as a way to discourage hypochondriac complaints. Available evidence shows that this argument for deductibles is rather weak. Statistics from Canada reveal that only large families have been discouraged from seeking treatment by deductibles.

Canadian officials from one of the Western provinces also discovered that the enormous bureaucratic costs involved in administering a system of deductibles wipes out much of the savings. It is not surprising, therefore, that the Canadian has totally eliminated deductibles.

The concept of deductible or coinsurance is unfair to the lower income groups. If there is a $500 bill a $100 deductible would be a hardship for low-income groups to come by by any of the poor, thus discouraged needed treatment. There should be no out-of-pocket expenses.

PROGRESSIVE FINANCING

A significant portion of the funding to any national health insurance program should come from general revenue funds, which are raised through a progressive tax. A second source of funding could be the payroll tax. ADA opposes any form of payment on a per capita basis. This is the way health insurance is presently financed, and it is clearly regressive.

Many unemployed, elderly, incapacitated and single-parent families have no income. Under no condition should these people be forced to suffer any stigma as a result of their accepting Government aid. No designation of these individuals as so-called "charity" recipients should appear on identification cards or medical records.

INCENTIVES FOR EFFICIENCY

The method of payment to health providers should be aimed at promoting the efficient use of health resources. One of the best ways of encouraging efficiency is to create incentives for group practices and health maintenance organizations. This can be done through encouraging use of per capita fees rather than fees for service. Per capita fees not only would lessen the individual doctor's paperwork, but would encourage hospitals to share rather than duplicate costly and presently underutilized medical equipment. Furthermore, it would encourage eliminating the 100,000 empty beds as well as the 250,000 beds that may be needlessly occupied. A 1975 study by "Public Citizen" put the combined annual cost for these two figures at $8 billion.

CONSUMER INVOLVEMENT

Despite the media's tendency to focus on the spectacular achievements of major medical centers, for example, organ transplants in Houston, the vast majority of health care activities take place in local communities. The specific needs of a local community are best understood by its members. Therefore, any and all administering agencies should reflect the community's ethnic, racial, and socioeconomic composition. Furthermore, these agencies should be held accountable primarily to consumers—not health care providers.

FULLY INTEGRATED SYSTEMS

For far too many people the term "health care provider" means medical doctor. The truth is that M.D.'s comprise only 7 percent of the health care providers. Under the present system hospitalization by an M.D. is the court of first resort, since this greatly enhances the incidence of payment by the insurance industry.

National health insurance should cover treatment by nurse practitioners, physician's assistance, and all other health providers. Furthermore, long-term care for the elderly should be developed to encourage treatment at home whenever possible. A program with these features would free doctors to take care of problems they alone could handle and eliminate unneeded hospital and nursing home care.

INCENTIVES FOR RURAL AND INNER-CITY PRACTICES

It is a well-worn cliche that "there is no shortage of doctors, only a maldistribution." While the shortage question is debatable, maldistribution is a demonstrable fact. Today there are millions of rural and inner-city residents, because they lack access to medical facilities, who are in constant danger that a simple injury or illness will turn into a medical calamity.

While Americans for Democratic Action would welcome establishment of a medical service corps comprised of doctors willing to serve in neglected areas for a short period of time, for example, recipients of scholarships seeking to meet a financial obligation to the Federal Government, such a corps cannot be viewed as an adequate substitute for a stable, community-based health care program.

To develop the kind of health care needed, a national health insurance program will have to offer inducements in finance and facilities. Proper health care for all is not a matter which can or should be left to laissez-faire economics.

Of the existing bills before the Congress today, H.R. 21, the Health Security Act, comes closest obviously to fulfilling the health care goals of the Americans for Democratic Action.

In my personal opinion, it is very likely that in order to give equal and excellent health care to all, we will eventually need to develop a national health service rather than have national health insurance alone. This may be necessary in order to keep the health care system from being fragmented.

The maldistribution problem is the greatest problem. Consequently I believe that a regionalized system not based on geography or the States, but on population units, must be organized. For a country of 200 million it might be appropriate to have 200 centers, each one caring for 1 million people. Obviously someone more knowledgeable than I might choose to have 100 centers caring for 2 million each. Perhaps for Alaska there may be another solution since there are not 1 million people there.

But then there might be 10 spokes in a wheel to community centers caring for 100,000 people and then 10 more spokes so that there are now primary care centers for 10,000 people each. The latter is where primary care is given.

In Montana this area would be large while in New York City it would be small. Each health unit in the primary care center of 10,000 up to the major center of a million and up to the largest national unit in Washington must be in the hands of a board of control. This includes a representative mixture of health workers, administrators, and consumers.

All care would be given in groups. Though the primary care centers would be where the people are, sometimes in very rural areas the health record would be as much a part of the larger medical center complexes as the subspecialists who are geographically in the center. Essentially all facilities necessary to take care of anyone would be in rural areas as well as large cities. This would be such things as electronic testing of patients' blood or by virtue of having a transportation wing of the health care system to rapidly transport patients to the major centers when necessary.

We must not lose sight of the needs for teaching and research which must be coordinated with the patient care considerations. Since the centers would encompass not only dentists and nurses, but all health workers would be part of the complex, and since the primary care centers would also be part of the medical center complex and patient care and teaching would be part of the complex, and since research would be part of the medical center complex, it would be organized such that all these activities could function properly.

Research could still be esoteric, but it would mainly be relevant and related to the problems of health care. All health care students must get their education with cost and each regional population unit must have the same number of teaching units. Therefore, since there is a tendency for most people to get their education near where they live, ~~there is a much greater chance that~~ the health workers on completing their education will work where they live. Gradually an even distribution of health care will then be possible.

Obviously, with a system such as the above, all health workers would be salaried, perhaps with an incentive plan. There would be much in favor of then also nationalizing other support industries such as the pharmaceutical industry and hospital supply companies.

Thank you very much.

Mr. COTTER [presiding]. Thank you very much for a fine presentation.

Are there any questions of the witness?

Mr. DUNCAN. I have none, Mr. Chairman.

Mr. COTTER. Mr. Crane?

Mr. CRANE. Thank you. I have just a couple questions.

You talk about the lack of overall national planning having resulted in 100,000 empty beds over and above the generous 15 percent reserve recommended by Hill-Burton.

My understanding is that of the 18 city hospitals in New York that their occupancy rate is about 25 percent and that presumably is the system where there is some planning, a determination is made as to provide facilities available to one and all on demand. I am wondering why you have confidence that the New York experience would not be emulated nationally.

Dr. LIEBMAN. Well, I think one thing, that that is a local problem. It is a matter of funding and it is a matter of where the hopsital beds are. I think people who may need these beds are not where they are—people who live in suburban areas in Long Island, who may very well have not enough hospital beds in their area, could well use those beds. Yet they don't want to come down there.

I think that is a very important problem.

Mr. CRANE. Well, I don't know the location of the facilities. I agree it is a very important problem. But it does seem to me that with the transportation network that they have in the greater New York City area there would be a minimum of inconvenience and vastly less inconvenience to those people than, say, in Great Britain suffered by an individual trying to find a hospital to get into.

Dr. LIEBMAN. I think one should also remember that the planning which is very spotty came mostly after most of the hospitals were built. I think that there are large major centers very close to other major centers doing the same sort of thing. That is why the beds are empty.

Mr. FIELDS. Can I add something, Mr. Crane? I think one of the great stimuli for eliminating this absurd waste in bed numbers in New York—and I understand, by the way, they are planning to close at least one hospital in the central Bronx—but I think that H.R. 21's budgetary system. Telling people how much money they are going to have at the beginning of the year is bound to encourage efficiency, rather than what has virtually been open-ended funding. I am hardly here to defend New York's fiscal policies, as a matter of fact, I am supposed to be involved in a seminar on the subject at 12—but the fact is that when people know how much money they have in the beginning of a year, they are bound to spend that money far more wisely than when they feel they have open-ended funding or bond rollovers.

Again I don't want to get into New York's fiscal policy.

Mr. CRANE. Let me get to one other subject that you touched upon. This is the fact that maldistribution is a very real problem that we have here in the United States. But, on the other hand, can you tell me a system anywhere in the world that does not suffer from maldistribution?

Dr. LIEBMAN. There is no system that doesn't suffer from maldistribution. It so happens in this country we suffer from it more by virtue of the kind of country that we have.

Mr. CRANE. Before you go further, what documentation do you have to support that allegation that we have a greater maldistribution problem? Let's avoid the subject of specializations for the moment. Let's talk about geographic maldistribution in terms of time that a person is in commuting distance from a hospital facility or a physician or in terms of percentage of population that resides in doctorless counties.

Dr. LIEBMAN. I think that is very well documented. The counties of East Texas and Tennessee, their mortality rates are fantastic from serious diseases, and it is mainly because there are no physicians there and they cannot get to the physicians.

Mr. CRANE. Do you know what percentage of our population lives in doctorless counties in the United States?

Dr. LIEBMAN. No; it is different in different areas.

Mr. CRANE. No; the percentage of population living in doctorless counties only. It is 0.2 of 1 percent.

Dr. LIEBMAN. There are 23 doctorless counties in Georgia.

Mr. CRANE. Do you know how many total counties in the United States are doctorless?

Dr. LIEBMAN. No, I don't know that number.

Mr. CRANE. Of 3,084, 132 are doctorless counties. They range from Hinsdale County in Colorado that has 202 people by 1970 census figures, and I think you don't find doctors in Hinsdale County in Colorado for the same reason you don't find supermarkets there.

Would you not agree that it would be a misallocation of a scarce resource to put a doctor in Hinsdale County, Colo.?

Dr. LIEBMAN. No; but they were planning—it might well be that three or four counties in that area together with an excellent transportation system could work together with health practitioners, et cetera, and have excellent care.

Mr. CRANE. Some doctors are doing that and thanks to our transportation network in this country, our highway system, there are a number of doctors who do practice in doctorless counties. I mean they don't maintain full-time practice there nor reside there, but of those 132 counties I mentioned 36 of them are adjacent to standard metropolitan statistical areas (SMSA's) and maybe you are familiar with Stafford County here in Virginia, which by 1970 figures had a population in the neighborhood of 26,000 and was a doctorless county. But it is about a 15-minute drive from the heart of that county down to Fredericksburg, which has about 48 physicians, or 15 minutes north into Prince William, which had 50 physicians at that time.

Of those counties there were 32 that had at least two doctors of osteopathy practicing that were not counted, they were classified as doctorless counties even with them there.

If you look at the system in Great Britain, for example, you will find that there is a greater maldistribution geographically in terms of the time it takes a person to get from a doctorless area to where he could find a doctor than we have here.

Dr. LIEBMAN. I don't believe that is true for many areas of this country, such as eastern Kentucky and eastern Tennessee and Wyoming and Montana. I would like to bring up Ohio, which is not considered one of the rural areas, where I come from. I will bring up a comparison with New England.

New England has 12 million people. Ohio has a little over 11 million. These are very comparable. In New England there is a regional infant cardiac program sponsored by the Federal Government such that babies with certain types of transposition of the great arteries—blue babies—can be transported to regional centers. Once they instituted that system, within a year they doubled the numbers of babies that were found with this condition. All the others were dead because this results in death before a month of life usually.

Ohio has no such program and despite the same population we find only exactly half the number. So, in other words, New England doubled its number as soon as it had the program. Ohio has no program and has the same number of cases that New England used to have.

Mr. CRANE. Have you seen comparable statistics for Great Britain?

Dr. LIEBMAN. Yes; and they find more transposition babies per 100,000 population than we do. And it is the same population ethnically.

Mr. CRANE. No; I don't think you can make that generalization.

Great Britain is the same population as the United States ethnically.

Dr. LIEBMAN. There is no genetic evidence to indicate that the population of Great Britain would have a different incidence of this type of blue baby than that of the United States.

Mr. CRANE. I see what you mean. All right.

With respect to the maldistribution in terms of specialization, which is creating maldistribution problems, would you agree that the Government itself through a variety of incentives for specialization provided through the years has contributed to that maldistribution problem?

Dr. LIEBMAN. No; I don't know. I believe the maldistribution problem is mainly because of a laissez-faire attitude that we have had of physicians, having gone through all their training, wanting to do what they want to do. That is where the major thing comes from and because of the fact that they do not want to go back to their rural areas.

I can give you something in that area. There are kids who come from, say, rural areas in Georgia. When they start medical school in the North, they say and they believe it, that they want to go back to their rural area. And when they finish their training they may try it. But when they get down there, the facilities are so bad by comparison to what they are used to that they don't stick it out.

I think that is very important. We must have the same facilities everywhere.

Mr. CRANE. I understand. If you had a type of sophisticated specialization where the demand for that service in a low population area would not be great, but you would reject totally the idea that the Federal Government through a variety of incentives in the area of specialization has not been a factor in contributing to the maldistribution that is the result of the surplus of, overemphasis on specializations.

Dr. LIEBMAN. I believe I would stay with what I have stated.

Mr. CRANE. No other questions, Mr. Chairman.

Mr. COTTER. Thank you very much.

Mr. ROSTENKOWSKI. The meeting will stand adjourned until 10 o'clock tomorrow morning.

[Whereupon, at 12:12 p.m., the subcommittee adjourned, to reconvene at 10 a.m., Wednesday, November 12, 1975.]

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